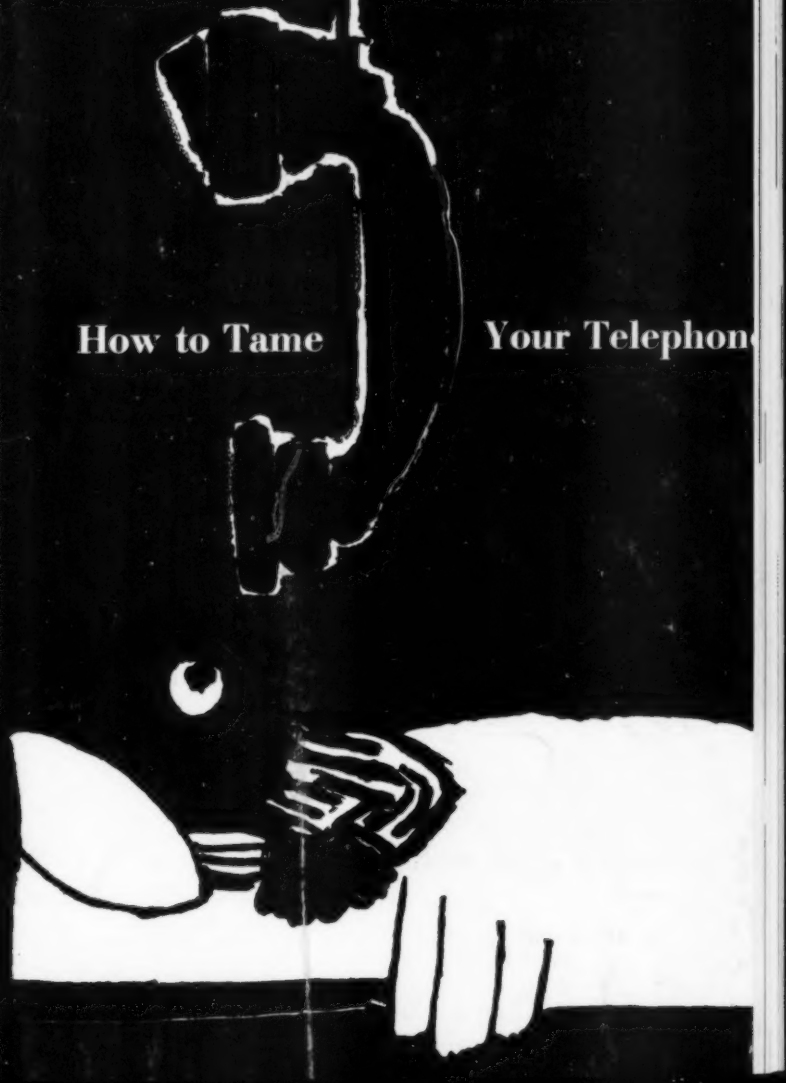
ebruary, 1956

Medical Economics



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1. McHardy, G., and Browne, D.: South. Med. J. 45:1139, 1952. 2. Johnston, R. L.: J.Ind.St.Med.Assn. 46:869,1953.

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FEBRUARY, 1956

Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS

SPECIAL FEATURES

MORE ►

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Each brown and white capsule contains:
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SPECIAL FEATURES (*Cont.*)

YOUR PRACTICE

YOUR FINANCES

MORE ▶

when they don't eat enough

G

or won't eat in balance

R

here's a new way to help them

O

outgrow their clothes . . . and . . .

W

perk up their lagging appetites

T

delicious melt-in-the-mouth flavor, too

H

STIMAVITE* TASTITABS*

for growth

Each STIMAVITE Tastitab contains:

Vitamin B_1 . . . . . 10 mg.
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Dosage: One tablet daily as a dietary supplement. The tablet may be swallowed whole, allowed to melt in the mouth, or can be dissolved in fluids.

Supplied: Bottles of 30 tablets.

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YOUR FINANCES (*Cont.*)

YOUR PRIVATE LIFE

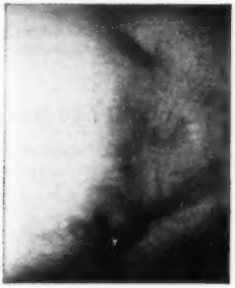
SHORT FEATURES

DEPARTMENTS

MORE ▶

New Relief from the Enigmas of Pruritus Ani

CASE – MALE, 55 YEARS



BEFORE

Rectal itch for 20 years; itching in rectal area extending across perineum to scrotum in wide area. Red scratches in perineal region. Severe erythema. Areas sensitive, painful, tender

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Therapy is based on the observation[1,2,3] that this non-irritating protein counteracts the protein-precipitating irritant responsible for the pruritus and is protein-sparing to perianal tissue.

AFTER

Hydrolamins applied 3 times daily to whole area. No irritation developed. Itching relieved immediately, and healing was complete in three weeks.

FORMULA:

Hydrolamins offers an isotonic, specially selected combination of amino acids derived from lactalbumin, in a vehicle of polyethylene glycol 1500.

SUPPLIED:

1 oz. (28 Gm.) and 2.5 oz. (70 Gm.) tubes with peel-off label.

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REFERENCES:

1. Bodkin, L.G. Amino Acid Therapy for Pruritus Ani. Am. J. Surg. 82:557 (Nov.) 1951.
2. Bodkin, L. G., and Ferguson, E. A., Jr. Successful Ointment Therapy for Pruritus Ani. Am. J. Digest. Dis. 18:59 (Feb.) 1951.
3. McGivney, J. Recent Advances in Proctology. Texas J. Med. 47:770 (Nov.) 1951.

NEWS

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MORE ▶

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Lactofort improves the protein quality of milk to a point where it approximates that of high-quality meat.

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2 measures (2.3 Gm.) of Lactofort supply:

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Vitamin A acetate	3750 U.S.P. Units
Vitamin D	1000 U.S.P. Units
Thiamine mononitrate	0.75 mg.
Riboflavin	1.25 mg.
Niacinamide	7.5 mg.
Vitamin B_{12}	2.5 mcg.
Folic acid	0.25 mg.
Ascorbic acid (from sodium ascorbate)	75 mg.
Pyridoxine hydrochloride	0.75 mg.
Calcium pantothenate	7.5 mg.
Iron ammonium citrate green (elemental iron 7.5 mg.)	50 mg.
Calcium gluconate (elemental calcium 130 mg.)	1.45 Gm.

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Relief of temporary constipation: Agoral is suited to the acutely constipated patient who can neither take time off for a "purge," nor time-out to answer the sudden urge induced by strong laxatives: the head of a one-man business; the executive committed to a day of important conferences; the bus driver on a long haul; people in the theatre, the pulpit, the factory, the home. For all who need relief of temporary acute constipation, pleasant tasting Agoral provides positive results without urgency.

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Supplied: bottles of 6, 10 and 16 fluid-ounces; and as Agoral Plain (without phenolphthalein), bottles of 6 and 16 fluid-ounces.

Agoral®

mineral oil emulsion with phenolphthalein

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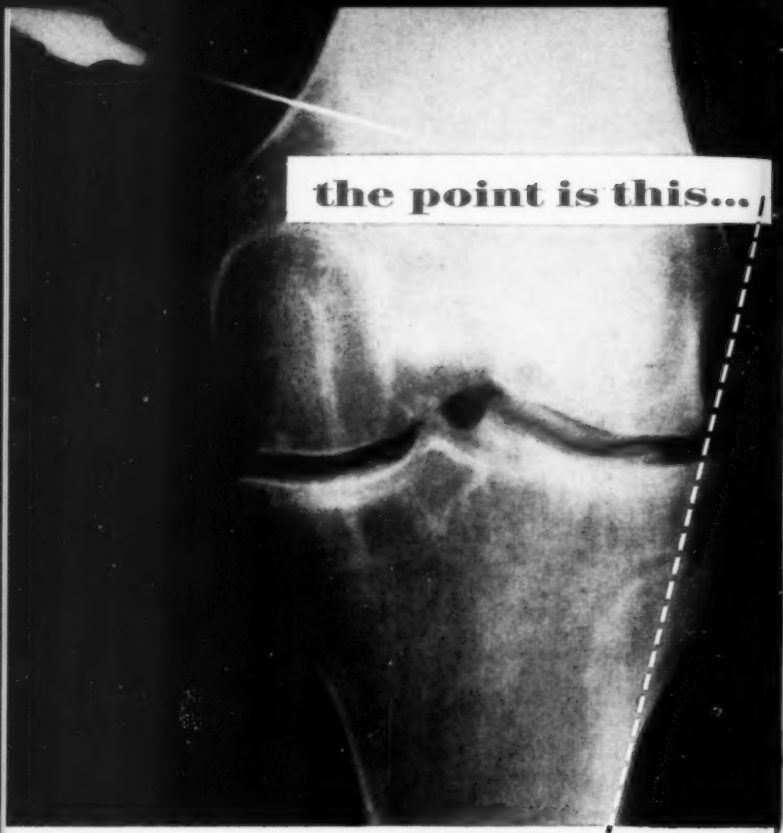

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gives the arthritic patient more days of freedom from joint symptoms—in many patients the anti-rheumatic effect persists 2 to 10 times longer than after injection of hydrocortisone acetate. Its action is local and without systemic effect.

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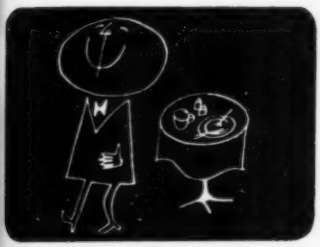
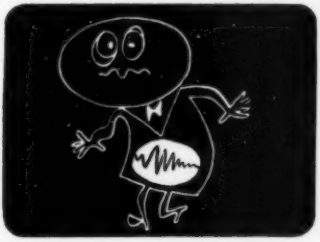
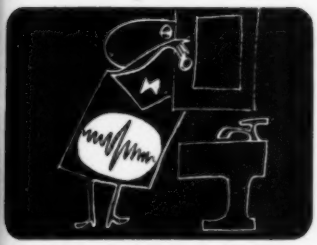
shortest distance to relief via the **AL-CAROID** route



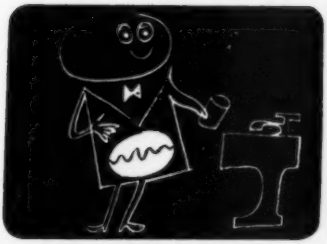
All's right with the inner man.



Whoops! Storm's a'brewin'!

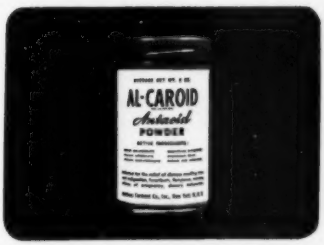


Al-Caroid to the rescue.



Like Doctor says — Al-Caroid works!

Thanks Doctor! Thanks Al-Caroid!



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Al-Caroid® is more than "just an antacid"

Its effective acid neutralizing properties provide a plus feature with its Caroid content. Caroid, a proteolytic enzyme, is effective in both acid and alkaline media.

Al-Caroid is a natural for your dyspeptic patients who require both antacid and protein digestant aid for full relief from heartburn, flatulence and general digestive upsets.

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News

Medical dean assumes high Government post • Physician sues grievance committee • 'Surgeons are singled out as whipping boys,' says Hawley • Forced service in free clinics decried • Doctors and reporters clash

Doctors' Vaccine Policy Still Stirs Public

Distribution of Salk vaccine is still the subject of heated debate. Doctors want it distributed through commercial channels; but in some areas, they've had to buck irate citizens who want it distributed through free vaccine clinics.

Typical of such areas is New Jersey. There, the disinclination of doctors to staff free Salk clinics has been called a "strike" and a "boycott" by the lay press. Even the conservative Newark Evening News has been sharply critical. In a recent editorial, the News charges that by "obviously limiting distribution" of the Salk vaccine, the doctors may be producing "the perfect climate for nurturing socialized medicine."

In reply to such criticism, the state's medical men are trying to make their position increasingly clear. Among their arguments:

¶ *The free-for-all clinic violates the principle of free enterprise.* Says Dr. Vincent P. Butler, president of the state society: "The Federal Government has no right to drop a load of vaccine in here and say: 'You have to inoculate these people regardless of their ability to pay.'" And Dr. Frank S. Forte of Newark adds: "You're reaching into the first stratum of socialized medicine" when you give free shots to people who can pay for them.

¶ *There's no question of denying shots to the medically indigent.* Charges that New Jersey doctors are "deficient in humanitarian impulses [are] neither fair nor just," says Dr. Butler. He explains that the state's medical men are pledged to give shots of state-supplied vaccine to all children and pregnant women whom they judge to be indigent. (For other patients, the usual fee in New Jersey is $12 to $15 for the three-shot series.)

¶ *There are medical drawbacks to free-clinic injections.* Clinic pa-

tients usually aren't examined, the doctors point out; nor are their medical histories taken. So fever, allergy, and other conditions may go undetected.

'Luxury Tax Should Pay For Indigent Care'

Despite the growth of health insurance plans, many Americans remain "uninsurable." Observing this, Dr. Royal A. Schaaf, past president of the Medical Society of New Jersey, has come up with a plan to provide for those "uninsurables" who are medically indigent. His frank suggestion:

"Pay for such services by money obtained from a subsidy provided by municipal, county, state and/or national government units." The money could be raised, the doctor believes, by means of "excise taxes on luxuries and amusements." Such taxes were reduced by nearly $1 billion in 1954. "Think," he points out, "how far this sum would go toward paying for medical and hospital care for 'uninsurable' people!"

Would all this money be sent to Washington? "No, indeed!" says Dr. Schaaf. He proposes that it be used in the state where raised, "except that 10 or 15 per cent . . . might be sent to Washington for distribution to certain of our less fortunate states in the deep South." He doesn't think Federal control would be a factor if the plan were administered by state boards "similar to the Selective Service Boards."

Schaaf

Dr. Schaaf emphasizes that this is no "visionary" dream. "The Medical Service Administration of New Jersey . . . for the past ten years has carried out with great success . . . in the City of Newark what I am now proposing for our country," he says.

Higher Malpractice Coverage Urged

Some malpractice authorities maintain that low limits of insurance coverage discourage high claims. But Dr. Joseph F. Sadusk Jr., who heads the Medical Review and Advisory Board of the California Medical Association, disagrees. The board has discovered, he says, that "the problems connected with inadequate coverage have been increasingly great during the past sev-

Sadusk

Snapshots

BLUE SHIELD BUSINESS is big business for some doctors nowadays. One man in Michigan was paid over $200,000 for the care of covered patients in a recent twelve-month span.

ONE-DOCTOR HOSPITAL in Nome, Alaska, is the smallest accredited by the Joint Commission to date. Dr. Fred M. Langsam is the entire medical staff. Commission comment: "A wonderful example of a fine job done by a dedicated G.P."

MILITARY MEDICAL manpower continues to elude the armed forces. Almost half of their regular medical officer billets are unfilled.

PLANNING TO RETIRE SOON? You may find lots of professional companionship in Arizona. In recent years it has licensed 528 nonresident physicians who aim at semi-retirement there.

TELEPHONE TIE-UPS are being reduced in some doctors' homes by means of a private phone installation for the children. Not an extension, the extra phone is listed separately under the parents' names as "Smith children," for example.

eral years." Though writing for California Medicine, he points out that the problem isn't confined to his own state: It's "nation-wide, with particular emphasis recently in . . . New York, Illinois, Florida, Connecticut, and Maryland."

Experience in these areas, he implies, bears out his contention that "the day of the $5,000/15,000 and $10,000/30,000 coverage has passed." Physicians with such low coverage, he warns, "leave themselves open to financial ruin."

What, then, is adequate coverage? "In general," says Dr. Sadusk, "a coverage of less than $50,000/150,000 should be considered inadequate in these days, and generally it is well to have coverage of $100,000/300,000.

"For physicians engaged in particularly hazardous work, such as anesthesiologists, vascular surgeons and neurosurgeons . . . coverages up to $300,000/900,000 may be considered desirable . . . In California within the past few months, verdicts of $225,000 and $250,000 . . . have been awarded . . . for paraplegia following spinal anesthesia in one case and an aortogram in another."

How to Judge an Aide

What makes a secretary most worth hanging onto? *Initiative* and *loyalty*, according to a cross-section of the country's business executives.

Polled by the Underwood Corporation, the executives named *typing skill* as the dream aide's third most important quality. They attached relatively little importance to the secretary's age and marital status. One-quarter of the employers said the girl's age doesn't matter a bit.

Government Gets New No. 1 Physician

Dr. Lowell T. Coggeshall is the new special assistant for health and medical affairs in the Department of Health, Education, and Welfare—the Government's No. 1 doctor billet.

Secretary Marion B. Folsom's selection of Coggeshall brought to an end five months of speculation as to who would succeed Dr. Chester S. Keefer of Boston. Keefer held the $15,000-a-year position during the time of Mrs. Oveta Culp Hobby and the Salk vaccine furor.

Dr. Coggeshall, 54 years old, has been dean of the University of Chicago Division of Biological Sciences since 1947. He'll retain his title there during a year's leave of absence. Thus he'll remain nominally responsible for what is commonly regarded as the second largest medical teaching and research program in the country.

A.M.A. officers (whom Folsom consulted in advance) generally acclaimed the appointment as a

Snapshots

WHOSE POLITICAL IDEAS have come closest to your own? Given a three-way choice, private physicians voted as follows in an A.M.A.-sponsored sampling: Eisenhower, 50 per cent; Taft, 26 per cent; Roosevelt, 17 per cent.

DOCTORS ARE HIRING more high-level help. In ten years, there's been a 500 per cent increase in the number of R.N.s working in medical offices. The total now stands at 35,200.

NEW WRINKLE in health insurance is the paid-up policy—where premium payments cease at age 65 but benefits continue for life. The Metropolitan Life Insurance Co. has just introduced such a policy.

DOCTORS' WIVES might take a cue from Dr. Milton J. Brothers' spouse, Joyce. She became the second person to win top money on TV's "$64,000 Question." She's spending part of it equipping an office for him.

STOCK PRICES MAY TUMBLE again during the year, Wall Streeters predict. But their consensus is that any dip will be "painless."

good one. But Dr. Coggeshall could by no means be described as an A.M.A. candidate. The University of Chicago Clinics conduct a private as well as a charity practice with a full-time, salaried staff. According to recent legal interpretations in some states, this amounts to the "corporate practice of medicine."

Obviously, Folsom found no fault with the dean of a medical institution sometimes described as "second only to Harvard." Apparently he felt lucky to get Dr. Coggeshall in view of election-year uncertainties. The Chicago dean twice refused the job and finally was persuaded only by "my admiration for Mr. Folsom," he said.

Grievance Committee Sued by Doctor

Your colleagues on grievance committees can't expect to win popularity contests. But some of them are learning that they may risk more than unpopularity as a result of serving on such committees. Thirteen Georgia doctors, for instance, are now painfully aware of this fact.

More than a year ago, as representatives of the Fulton County Medical Society, they handed Dr. Wayne S. Aiken a six-months' suspension from the society. Now he's testing their right to do so in a $2.5 million damage suit. His charge: The doctors "conspired . . . to present him to the public, his patients, his friends, [and] his acquaintances . . . as guilty of . . . subordinating his profession to material gain."

In reply, the defendants argue that their action was taken "in performance of a duty . . . as members of the grievance committee and as members of the judicial council . . . in accordance with the [society's] constitution and bylaws." The case is due to reach court in the near future.

'Surgeons Are Singled Out As Whipping Boys'

Considering its touchy subject, the A.M.A. report on unethical practices* has been well received by the profession. But not by Dr. Paul R. Hawley, director of the American College of Surgeons. He says:

"Throughout the report, the income differentials among various fields of practice are repeatedly introduced. These are offered as the major, if not sole, reason for the existence of every evil. Surgeons are singled out as whipping boys. It is the higher income of surgeons which [according to the report] is responsible for unethical division of fees and for inadequately trained people doing surgery. Despite recognition in the text of the greater difficulties in establishing a surgical practice and the shorter period

*See July, 1955, MEDICAL ECONOMICS.

of earning power, these significant characteristics of surgical practice are wholly ignored in the conclusions."

Dr. Hawley appears particularly incensed at the reported professional attitudes toward fee splitting.

Quoting the statement that many doctors feel it should be "legalized," he says: "It is to be hoped that this is not a measure of the

Another M.D. Makes the Funny Papers

● These three Cleveland internists are serious readers of the "funnies." And with good reason: They are the creators of "Dr. Guy Bennett," the latest—and one of the best—medical strips. Dr. Michael A. Petti (left) writes the script, under the pen name of Dr. B. C. Douglas. His wife, Dr. Helen M. Thompson, contributes ideas. And Dr. Donald B. Cameron is the model for the fictional Dr. Guy Bennett (➤). Like its doctor-written precursor, "Rex Morgan, M.D.," the new strip is entertaining, informative, and authentic.

profession's willingness to compromise with evil solely for the purpose of filling the wallets of doctors."

'Blue Plan Contracts Must Be Simplified'

"Ambiguous terminology" must be eliminated from Blue Cross and Blue Shield contracts. Otherwise, doctors may soon turn against the very insurance plans they helped create. Such, at least, is the warning of T. H. Hammond, assistant general manager of the Oregon Physicians' Service.

Too many of the contracts, he argues, rule out coverage of "congenital," "pre-existing," and "chronic" conditions, or of "diseases peculiar to sex." Such terms are so "vague and meaningless," he maintains, that it's often completely impossible to apply them to specific medical cases.

The burden of trying to do so usually falls on the doctor. As a result, the medical man is caught in a cross fire between insurers and insured. "In one instance," says Hammond, "the physician is a 'wonderful fellow' to the patient and a so-and-so to the prepaid plan. In the next, he may be vice versa."

The answer to the problem: "revision of prepaid contracts to el-

iminate vague terminology." Further simplification, Hammond believes, is the way to take the pressure off the nation's doctors.

Ike's Case Expected to Boost Heart Gifts

With its annual fund-raising campaign getting under way this month, the American Heart Association boasts the most important ally in its history: President Eisenhower. There's little doubt that he's become associated in the public mind with the fight against heart disease, just as F.D.R. symbolized the crusade against polio.

For two months following Ike's attack, heart association executives point out, the association was flooded with inquiries about the disease. And there's been a spurt of local fund-raising campaigns in the President's name, despite lack of official sanction.

As a result, the association may top its unofficial 1956 goal of $16 million by a good bit—possibly by as much as four or five million dollars.

Wanted by an Isolated Island: One G.P.

If you're tired of practicing in a noisy city or faceless suburb, the Virginia Council on Health and

Medical Care may have just the job for you: a small but steady practice on the quaint little island of Tangier, twelve miles offshore in Chesapeake Bay.

Dr. Charles F. Gladstone has cared for the island's 1,000 residents for over thirty-seven years. Now he wants to retire. As of this writing, only one medical man—a Russian D.P.—has volunteered to take over. Unfortunately, he hasn't yet been able to pass the State Board examinations.

Life on the island is apparently unique. Says one observer: "It has . . . remnants of eighteenth century speech and customs. It's a sort of Virginia Nantucket, with overtones of Netherlands canals and Cornwall fishing villages."

Sound good? Well, here's a word of caution from a Tangier civic leader: Though the island would welcome you with open arms, "only that doctor who is moved by a high missionary calling to serve where the need is greatest" is likely to find the place bearable.

'Family Health Record' Serves Patients Well

Another new service for patients is going over big. For some months now, Connecticut doctors have been distributing a sixteen-page "Family Health Record," which is

the only broad spectrum antibiotic preparation that:

1 provides the antimicrobial activity of tetracycline

Because it contains Steclin (Squibb Tetracycline), the well tolerated broad spectrum antibiotic, MYSTECLIN is an effective therapeutic agent for many common infections. Most pathogenic bacteria, as well as certain large viruses, certain Rickettsiae, and certain protozoans, are susceptible to Mysteclin.

2 protects the patient against monilial superinfection

Because it contains Mycostatin (Squibb Nystatin), the first safe antifungal antibiotic, MYSTECLIN acts to prevent monilial overgrowth frequently observed during broad spectrum antibiotic therapy. Manifestations of this overgrowth may include some of the diarrhea and anal pruritus associated with antibiotic therapy, as well as vaginal moniliasis and thrush. On occasion, serious and even fatal infections caused by monilia may occur.

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(SQUIBB TETRACYCLINE-NYSTATIN)

A PARTIAL LIST OF INDICATIONS FOR MYSTECLIN

When caused by tetracycline-susceptible organisms, the following conditions are among those which may be expected to respond to Mysteclin:

Abscess
Bronchiectasis
Bronchitis
Bronchopneumonia
Burns, Infected
Cellulitis
Cervicitis
Chancroid
Colitis
Cystitis
Diarrheas, Infectious
Diphtheria
Dysentery, Amebic
Dysentery, Bacillary
Empyema
Endocarditis, Bacterial
Epididymitis
Erysipelas
Furunculosis
Gangrene
Gastroenteritis
Gonorrhea
Granuloma Inguinale
Klebsiella Pneumonia
Laryngitis
Lymphadenitis
Lymphangitis
Lymphogranuloma Venereum
Mastoiditis
Meningitis
Metritis
Osteomyelitis
Otitis Media
Peritonitis
Pertussis
Pharyngitis
Pinworm Infestation
Pneumonia
Psittacosis
Pyelonephritis
Q Fever
Rocky Mountain Spotted Fever
Salpingitis
Scarlet Fever
Scrub Typhus
Sepsis, Puerperal
Septic Sore Throat
Septicemia
Sinusitis
Skin Graft Infections
Surgical Prophylaxis
Tonsillitis
Tracheobronchitis
Tularemia
Typhoid Fever
Typhus
Urethritis
Vesiculitis
Vincent's Infection
Wounds, Infected
Yaws

It is impossible to predict with certainty in which patients clinical moniliasis may develop as a result of broad spectrum antibiotic therapy. However, the added protection afforded by Mysteclin against monilial superinfection is especially important in patients who are debilitated, elderly, or diabetic, or when antibiotic therapy must be prescribed in high dosage or for prolonged periods. It is also important in infants (particularly prematures), as well as in patients for whom concomitant cortisone or related steroid therapy is prescribed, or in subjects who have developed a monilial complication on previous broad spectrum therapy.

Mysteclin is particularly useful in women, inasmuch as they not infrequently develop vulvovaginal moniliasis after treatment with ordinary broad spectrum antibiotics; this is especially common in women who are pregnant or diabetic.

published by their state medical society. The booklet provides spaces for the recording of immunizations and tests, physical examinations, injuries, illnesses, and hospitalizations. A chatty introduction explains some of the record's uses:

"It is not a substitute for your doctor's records. But it should be of help when planning the care of your family... You'll find the booklet reassuring if you move into a new community. Your new family physician will appreciate it, too. He will be able to start medical histories for your family with certainty about dates and happenings."

The pamphlet even helps the patient with his financial affairs: "The last three pages provide space for... income tax deductions, the status of your health insurance, and telephone numbers for emergency use."

How They'd Like to Treat Military Dependents

Must doctors put on uniforms in order to treat servicemen's dependents? The physicians of San Diego, Calif.—an area with a heavy military dependent population—don't think so. When queried by the local Medical Veterans Society as to how they'd prefer to do the job, the overwhelming majority of the 455

respondents said they felt they could handle it as civilians, working on an insurance basis.

About 93 per cent of the doctors said they'd prefer to treat military dependents in the office; and all but 11 per cent of these expressed their willingness to accept a fee schedule. Only three men out of all those queried said they believed that the armed forces should continue to draft medical men to care for dependents.

Why They Don't Join

Why do some doctors stay out of their local medical societies? To find out, the Medical Society of the County of New York queried 1,000 eligible physicians who don't belong to it. Most of those who replied gave one of the following reasons for nonmembership:

¶ They think dues are too high.

¶ They see no benefits in belonging.

¶ No one has asked them to join.

Forced Service in Free Clinics Blasted

Some hospitals are *forcing* doctors to work in their clinics. This means that the physician is maneuvered "into a position of obligation to the hospital rather than to his community or his conscience." That's the opinion of Dr. J. Norman O'Neill, editor of the Los Angeles County Medical Association Bulletin.

What's worse, [MORE ON 264]

The "quick'n easy" of Low-Residue Diets...

With a can opener as key to this diet, your patient has a wide choice of strained foods. And these diet "do's" can guide him toward tempting dishes.

Vary the texture for taste appeal—

Consommé can be served hot with crisp croutons, or cold and jellied in shimmering peaks. Puréed vegetables folded into a beaten egg can be baked to a puff, or molded in gelatin. Eggs can be soft or hard cooked by simmering—or scrambled in a double boiler.

Serve prettily for eye appeal—

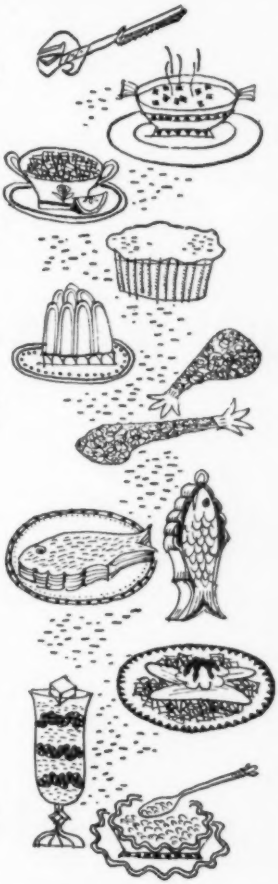
Chopped meat can be shaped like a chop—minced chicken like a drumstick—before baking. And flaked fish in lemon gelatin can be chilled in a fish mold.

Potatoes mashed with a little broth whip up creamy and light with cottage cheese.

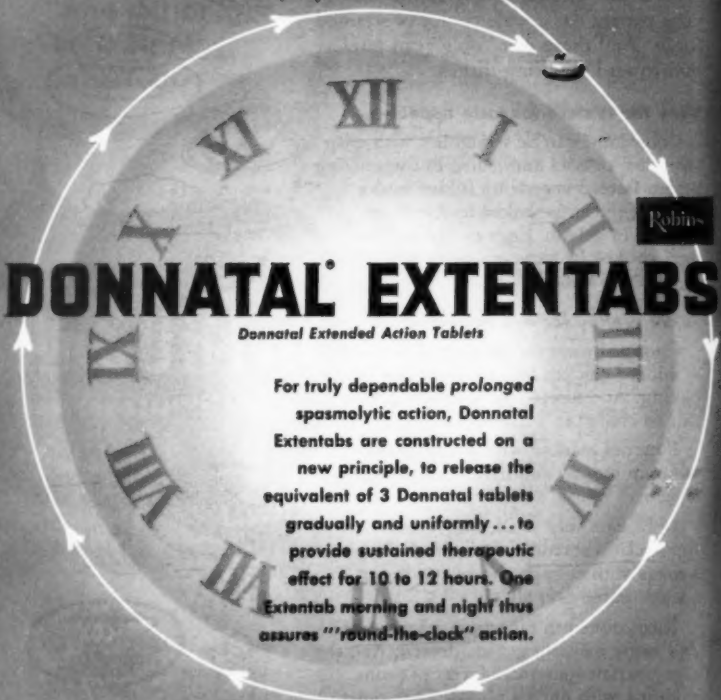
In banana split salad, the "greens" are lime gelatin shredded with a fork. Top the banana with cottage cheese and spoon apricot purée over all.

Rice cooked in pineapple juice, water, and sugar makes a golden dessert. And for a gay parfait—alternate layers of farina pudding with puréed plums. Then put a sparkling cube of clear jelly on top.

Of course, only you can tell your patient which foods he can have. And these ideas can help make them appetizing.



NOW—for p-r-o-l-o-n-g-e-d spasmolytic action—



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For truly dependable *prolonged* spasmolytic action, Donnatal Extentabs are constructed on a new principle, to release the equivalent of 3 Donnatal tablets gradually and uniformly... to provide sustained therapeutic effect for 10 to 12 hours. One Extentab morning and night thus assures "'round-the-clock" action.

Each Donnatal Extentab contains:

Phenobarbital (¼ gr.) . . 48.6 mg.

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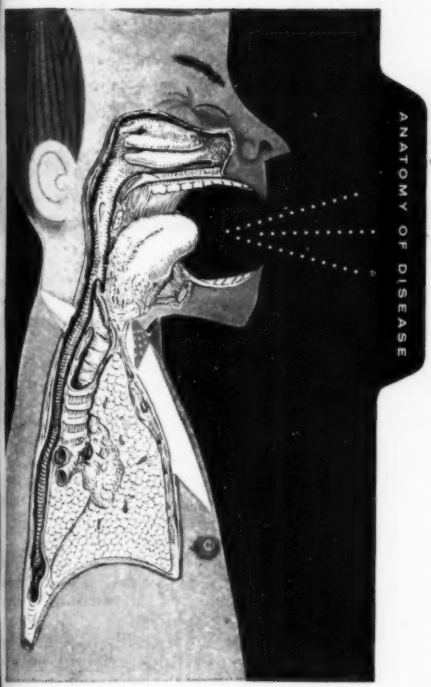

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TUSSAR is combined with dihydrocodeinone bitartrate—approximately six times as potent as codeine, allowing for lower dosage

TUSSAR is easy to take because of its pleasant flavor

16 oz. and gallon bottles

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Each fluidounce of Tussar contains:

Dihydrocodeinone Bitartrate Warning—may be habit-forming	1/6 gr.
Potassium Guaiacol Sulfonate, N.F.	8 gr.
Sodium Citrate, U.S.P.	13.2 gr.
Citric Acid	2 gr.
Prophenpyridamine Maleate (10 mg./teasp., 5 cc. medicinal)	1 gr.
Chloroform, U.S.P.	2 minims
Methylparaben, U.S.P.	0.1%
Flavor, preservative, sweetening, aroma, vehicle	

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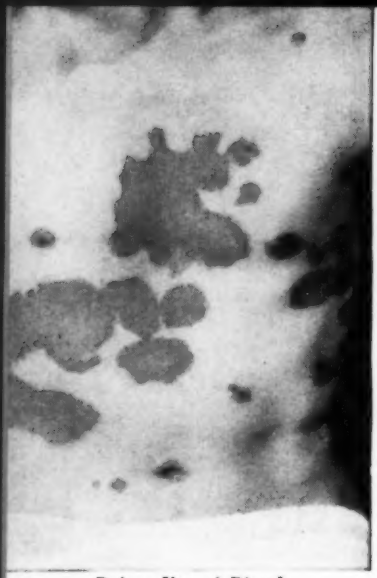
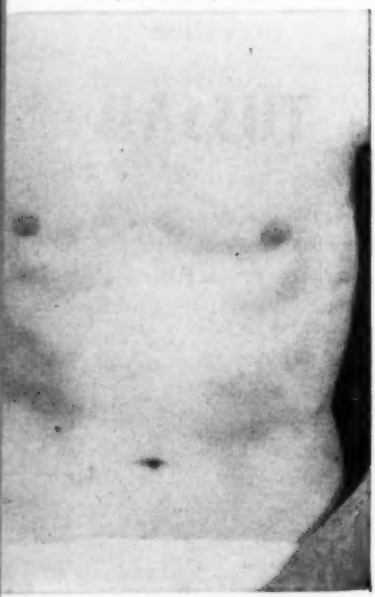


Before Use of Riasol



After Use of Riasol

COLD FACTS on RIASOL in Psoriasis

Cold weather aggravates the itching a eruptions of psoriasis. To keep the disea under control, many physicians prescri RIASOL.

Psoriasis is the 8th most common sk disease, 6% of all cases. Treatment in series of 231 cases with various drugs oth than RIASOL produced remissions in on 16½% cases.

RIASOL showed clinical improvement 76% cases of psoriasis. It proved satisfa tory in neglected cases. The skin lesio cleared up in an average of 7.6 weeks, 8 typical cases treated with RIASOL.

RIASOL contains 0.45% mercury che ically combined with soaps, 0.5% phen and 0.75% cresol in a washable, no staining, odorless vehicle.

Apply daily after a mild soap bath a thorough drying. A thin invisible, econo ical film suffices. No bandages require After one week, adjust to patient's progre

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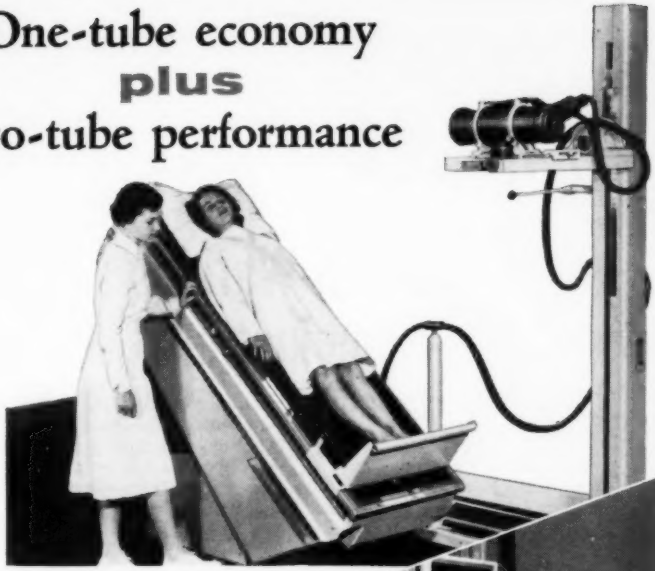

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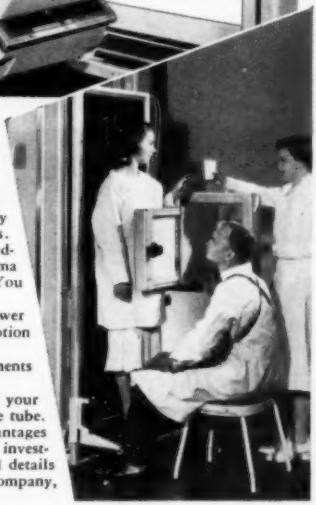
No need to buy! — If you prefer, enjoy all these advantages on the G-E Maxiservice® rental plan with *no* capital investment. Your G-E x-ray representative will give you full details . . . or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, for Pub. C-21.



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FOR YOUR CARE OF OBESITY... HERE'S

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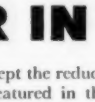
That's how Dietene Reducing Supplement was described recently by a Philadelphia doctor . . . and that's exactly what it is to your obese patients. Here's why:

DIETENE solves the uncomfortable problem of between-meal hunger. Two Dietene Milk Shakes daily supply 36 grams of protein, fortified with essential vitamins and minerals. Thus, through sound nutrition alone, DIETENE satisfies both body hunger and the psychological craving for "something good to eat". With the between-meal hunger problem licked, patients find it easier to accept the reduced portions of interesting foods featured in the Dietene 1000 Calorie Diet.

DIETENE contains no drugs. It is normally safe even for cardiacs and hypertensives. It tastes good, mixes easily with milk and is economical. DIETENE *assures patient cooperation.*



TRY THE DIETENE DIET

. . . based on DIETENE, *the original Reducing Supplement—regularly succeeds where other reducing regimes fail. Free diet sheet service.*

FREE 1 LB. CAN! MAIL COUPON TODAY!

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for more precise dosage

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Both tablets are deep-scored and of the SAME DISTINCTIVE "FINGER-GRIP" SIZE AND SHAPE for ease of handling and breaking by arthritic fingers.

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A single 'Prydonnal' Spansule capsule q12h provides 24-hour anti-spasmodic-antisecretory-sedative action that assures your patient distress-free days and undisturbed sleep throughout the night.

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The first dictation machine with fragile wax cylinders that had to be re-surfaced.

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First flexible plastic belt. A definite advance, but still costly, one use.

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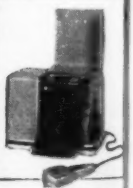
The amazing Comptometer Erase-O-Matic belt. Never wears out, can be used indefinitely, errors can be erased magnetically.



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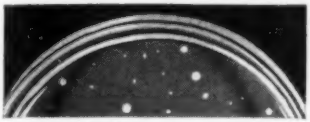
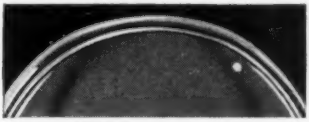
DIAL SOAP with Hexachlorophene
effects 95% reduction in skin bacteria

Photomicrographs show why



With ordinary soap. Even after thorough washing, thousands of active bacteria remain on the skin.



With Dial soap. Daily use of Dial with Hexachlorophene eliminates up to 95% of resident skin bacteria.

1. *Reduces chance of infection* following skin abrasions and scratches because Dial effectively reduces skin bacteria count.

2. *Stops perspiratory odor* by preventing bacterial decomposition of perspiration, known to be the chief cause of odor.

3. *Protects infants' skin,* helps prevent impetigo, diaper and heat rash, raw buttocks; stops nursery odor of diapers, rubber pants.

4. *Helps skin disorders* by destroying bacteria that often spread and aggravate pimples, surface blemishes.

You know, of course, the remarkable antiseptic qualities of Hexachlorophene soaps, as documented in recent literature. Dial was the first toilet soap to offer Hexachlorophene content to the public. You can safely recommend Dial. Under normal conditions it is non-toxic, non-irritating, non-sensitizing. Furthermore, Dial Soap is economical, and widely available to patients everywhere.

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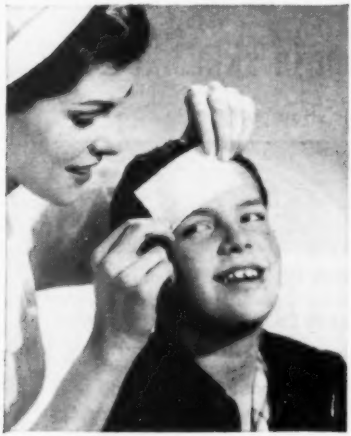

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USE TELFA WHEREVER WOUNDS ARE DRESSED

to speed healing, save dressing time

For routine use on all wounds...
absorbs without sticking, lifts off painlessly

Wounds that you now dress with gauze, or with sponges and pads, can be dressed *better* with TELFA—in half the time.

Better, because TELFA gives you fast, *primary* healing. With its perforated "plastic skin" that goes next to the wound, TELFA absorbs drainage without sticking and never interferes with *natural healing.*

You save time because, whether you use a small TELFA Strip or a TELFA Sponge-Pad, *one dressing is all you need.*

TELFA Strips in 2″ x 3″ and 3″ x 4″ sterile envelopes; in 2½″ x 4″, 3″ x 8″ and 8″ x 10″ hospital cases. TELFA Sponge-Pads in 4″ x 5″ and 5″ x 9″ hospital cases.

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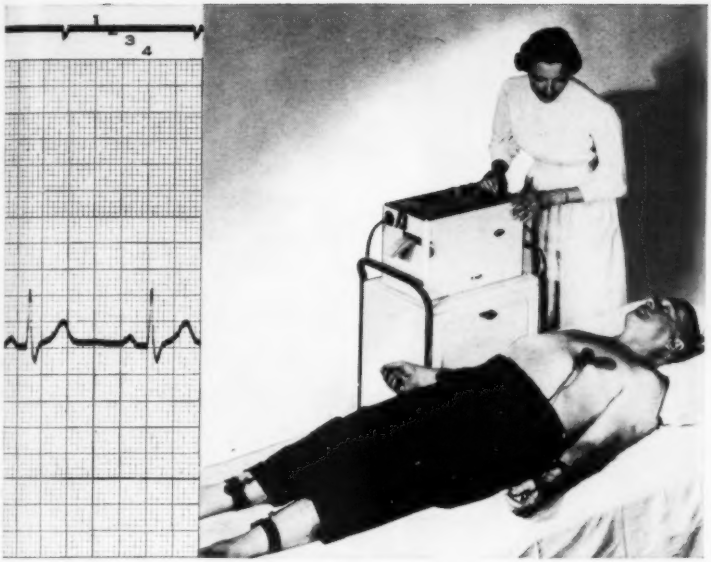

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Leads are marked automatically and are selected at the turn of a dial. The heat-sensitive paper moves at a calibrated speed, and the heated stylus writes directly on the paper. Timing is also automatic.

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Her most important asset is her *health*. ➤ With health, she is happy, relaxed and capable of serving her family and community. ➤ Today, parents turn to their family physician for advice on scientific methods of child-spacing, for it is he who recognizes the medical necessity for such advice . . . guides her . . . and earns her gratitude. Without this attention from her doctor, in whom she places her confidence, her family goals would not be easily obtained. It's the incomparable knowledge, skill and experience of her doctor...and doctors everywhere...whose judgment is to recommend for their patients' health and happiness — *Koromex*

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OINTMENT

rich in **cod liver oil**

in **diaper rash • wounds** (especially slow healing)
ulcers (decubitus, varicose, diabetic) • **burns**
dermatoses • rectal irritation

Tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars.

May we send **samples** *and literature?*

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1. Overall, J. C.: Southern M. J. 47:789, 1954. 2. Editorial: New England J. M. 246:111, 1952.
3. Grayzel, H. G., Heimer, C. B., and Grayzel R. W.: New York St. J. M. 53:2233, 1953.
4. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
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6. Turell, R.: New York St. J. M. 50:2282, 1950.

Letters

Licking the malpractice menace • Our 'ailing' hospitals • How to handle talkative patients • Anesthesiology as a specialty • Hiring a laboratory technician • How should Blue Shield fees be apportioned?

Medical Meetings

SIRS: You often hear the complaint that too many medical societies are run by cliques. But if this is true, whose fault is it?

The membership of my county society is something over 700; the average attendance at meetings, 100 or less. This situation is apparently typical.

Thus, a high proportion of the members voluntarily give up their right to express their opinions. And a handful of interested medical men have to run the organization.

Alexander A. Levi, M.D.
Boston, Mass.

SIRS: The Erie County (Pa.) Medical Society has the right idea for its committee meetings. The host, you said, "brings out some sandwiches or cold cuts and a little spiritual replenishment."

If more medical societies did this, doctors wouldn't be so notoriously reluctant about being herded into meetings. Let them test the pulling power of the so-called "hero" sandwich (bread, turkey, ham, tongue, sardines, cheese, and so on). In my experience, this sort of hospitality can attract larger audiences than the most distinguished lecturer.

Murray M. Marcus, M.D.
Brooklyn, N.Y.

Doctors' Fees

SIRS: Your article, "Surgical Fees Today," has some very practical information in it. But I'm sorry you didn't ask whether or not the surveyed doctors were participants in their local Blue Shield plans.

In our experience, most of the physicians who *don't* participate charge fees well above those paid by Blue Shield. This is probably the basic reason for their unwillingness to join . . .

W. H. Horton, M.D.
Connecticut Medical Service, Inc.
New Haven, Conn.

SIRS: As an average American housewife, I'd like to know what right doctors have to base their fees on the patient's income. No sales-

man charges an M.D. $3,000 for an appliance that costs other people $300; he charges what it's worth.

I'd like to see doctors set a firm price on their services, instead of hemming and hawing when asked what the fee will be.

Rose C. Huth
Webster Groves, Mo.

'Mad' Psychiatrists

SIRS: I agree heartily with most of the statements in Dr. Barton Lawden's article, "Why Psychiatrists Go Mad." But I *don't* agree that "there's no more reason for [a psychiatrist] to make house calls than for an ophthalmologist to do elective Caesarean sections."

People *do* get sick with psychiatric illnesses at home, and there *are* some psychiatric emergencies. Do you tell a man who's contemplating suicide that he must wait until a week from next Tuesday for an appointment?

Any man who considers himself a doctor must accept the responsibility for taking care of sick people within his field of practice. It seems to me that Dr. Lawden is confusing specialization with laziness . . .

Leonard J. Schiff, M.D.
Plattsburg, N.Y.

SIRS: Dr. Lawden's article is the best one you've ever published . . .

Not only do Blue Cross contracts

Syrup and oral tablets. Each teaspoonful or tablet of **HYCODAN** contains 5 mg. dihydrocodeinone bitartrate and 1.5 mg. Mesopin.* May be habit-forming. Average adult dose, 1 teaspoonful or 1 tablet after meals and at bedtime.

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BETTER THAN CODEINE **FOR COUGH**[1]

FASTER
LONGER-LASTING
MORE THOROUGH

BETTER THAN CODEINE *PLUS* APC **FOR PAIN**[2]

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(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC)

Scored, yellow oral tablets. May be habit-forming. Average adult dose, 1 tablet q. 6 h.

1. Hyman, S., and Rosenblum, S. H.: Illinois M. J. 104:257, 1953.
2. Piper, C. E., and Nicklas, F. W.: Indust. Med. 23:310, 1954.

†U. S. Pat. 2,638,185

Literature? write

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your best bet!

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discriminate against psychiatric patients, as the writer pointed out, but so do Government insurance proposals. Even the New Deal's socialized medicine program would have excluded psychiatry.

James A. Brussel, M.D.
Queens Village, N.Y.

Malpractice Menace

SIRS: In his article, "How We Can Lick the Malpractice Menace," the late Dr. Louis J. Regan did a good job of pointing out ways in which doctors can avoid malpractice suits. I must take exception, though, to his suggestion that most malpractice claims have no meritorious foundation.

In New York State, at least, a large majority of suits have a very solid foundation on malpractice error or mistake. Our county advisory committees have found this out when they've reviewed all the facts in cases against their members. As a result, the advisory committees no longer complain that too many malpractice suits are being settled out of court . . .

Harry F. Wanvig*
New York, N.Y.

Texas Medicine

SIRS: It's true, as you pointed out in your article on the Texas doctor, that Texans fiercely resist Federal interference in their affairs. Here's an example:

In 1953, Amon G. Carter, a prom-

*Mr. Wanvig is indemnity representative of the Medical Society of the State of New York.

inent publisher, gave a new building to the Fort Worth Academy of Medicine. He attached only one string to this gift: If the Government ever put through socialized medicine, he wanted the building back. And he meant it!

William M. Crawford, M.D.
Fort Worth, Tex.

NEVER-TO-BE-SOCIALIZED ACADEMY OF MEDICINE, FORT WORTH, TEX.

Hospital Problems

SIRS: I enjoyed Dr. Avery Compton's timely and impartial article, "What Ails Our Hospitals?" And I agree with him that we need younger and more active hospital board members . . .

At least one of those members should be a medical man who is unbiased, impersonal, and fearless in expressing his convictions . . .

Edward Palmer, M.D.
Berwyn, Ill.

SIRS: What ails *Dr. Compton?* He seems to feel that the administrator is out to fight a duel to the death with any doctor who dares to step into his office. But that type of hospital administration went out with Mother Fletcher's Rejuvenating Compound . . .

I'm a resident in hospital administration at Columbia University. And most of the administrators I know stay up nights trying to find ways to improve patient care. If—as Dr. Compton says—too many complaints "fall on deaf ears," the administrator will soon be looking for a new job.

Jerome G. Stewart
Brooklyn, N.Y.

SIRS: That article was the best bit of honest criticism I've seen in my many years as a reader of MEDICAL ECONOMICS. It's a realistic picture of too many hospitals today.

I pity the poor, unsuspecting patient: He's being milked of ever-increasing hospital fees, while newspapers, popular magazines, and self-styled community leaders try to persuade him that he never had it so good.

M.D., Massachusetts

Talkative Patients

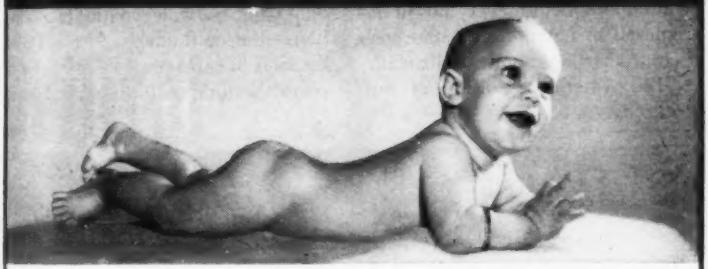
SIRS: Several times recently, you've mentioned the Cornell Medical Index, a health questionnaire that the patient can fill out before he sees the doctor.

I don't always use it. But I do when I have an overly talkative patient on my hands.

I ask him to fill the questionnaire out and to bring it back for a follow-up appointment, which my aide sets for the last period in the day. Then

Now...
a medically-
proven
way to

ACTUALLY PREVENT DIAPER RASH



A remarkable preventive now exists that could well make ammonia (common) diaper rash an almost *non-existent* infant disorder. Conclusive proof is at hand that Mennen Baby Magic Skin Care actually prevents diaper rash, and has effective healing powers as well.

In one series of tests, 85.5% of cases of ammonia diaper rash were completely cured, from a clinical standpoint. *There was only one recurrence while Baby Magic was being used!*

Baby Magic is a non-greasy emulsion of cholesterol and related sterols, lanolin, and contains the quaternary compound Methylbenzethonium chloride. It is quickly absorbed, fragrant, and has a deodorant action. It is excellent for all-over skin care.

Send for free copies of "Proper Usage of Mennen Baby Magic in the Hospital Care of the New Born". This booklet, prepared especially for doctors and nurses, includes the results of clinical studies. Write to The Mennen Company, Morristown, N. J.

MENNEN ... *Baby Specialist since 1880*

I spend as much time as necessary with him.

I keep track of the time I give him and charge for it at $15 an hour. So far, no one has complained.

Bernard P. Harpole, M.D.
Portland, Ore.

Anesthesiology

SIRS: Your article on anesthesiology is a clear, concise, and appealing presentation . . .

There's an increasing demand for modern anesthesia from patients and doctors alike. I don't think it will be long before every hospital is required to have at least one competent anesthesiologist on its staff.

The American College of Surgeons has already recommended this, and the A.M.A. concurs.

Stevens J. Martin, M.D.
Hartford, Conn.

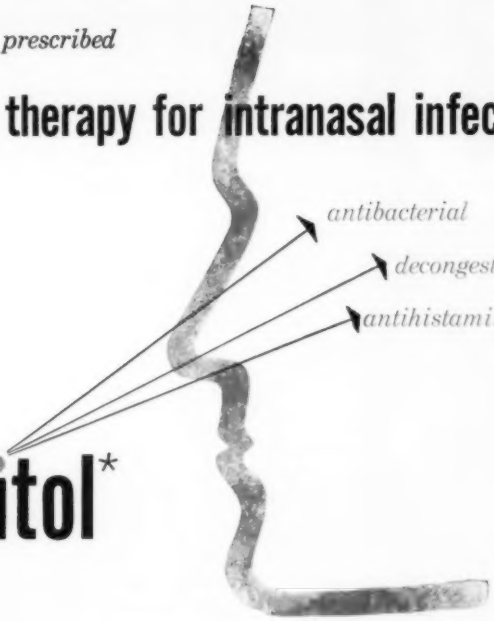
Cash Collections

SIRS: A few years ago, I was seeing far too many patients in my office. I had to cut each visit short to get through the appointment list. Many of my patients, I realized, felt slighted and hurried—and I wasn't satisfied, either. My collections were way below average.

Then I made up my mind to see only eight to twelve patients a day, depending on the type of case. I also decided to raise some of my fees to cover the additional time spent with

the widely prescribed

3-way therapy for intranasal infections



Drilitol*

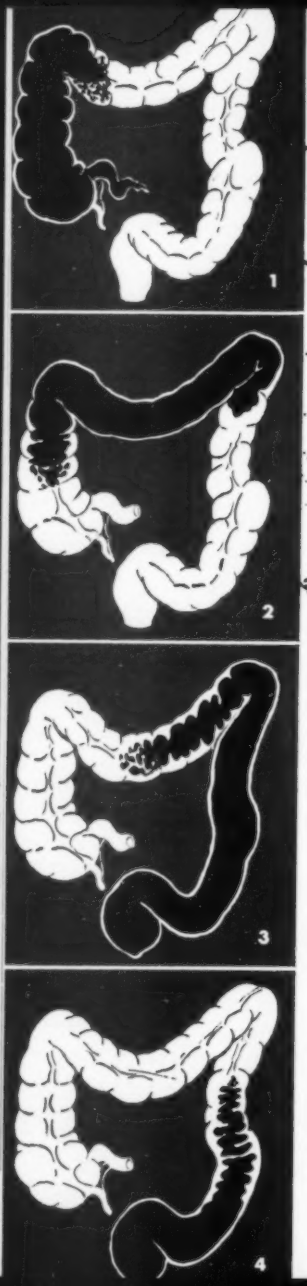
1. antibacterial—anti-grampositive gramicidin and anti-gramnegative polymyxin combat a wide range of bacterial invaders and curb complications.
2. decongestive—Paredrine† Hydrobromide promptly opens blocked intranasal airways.
3. antihistaminic—thenylpyramine hydrochloride relieves local allergic manifestations.

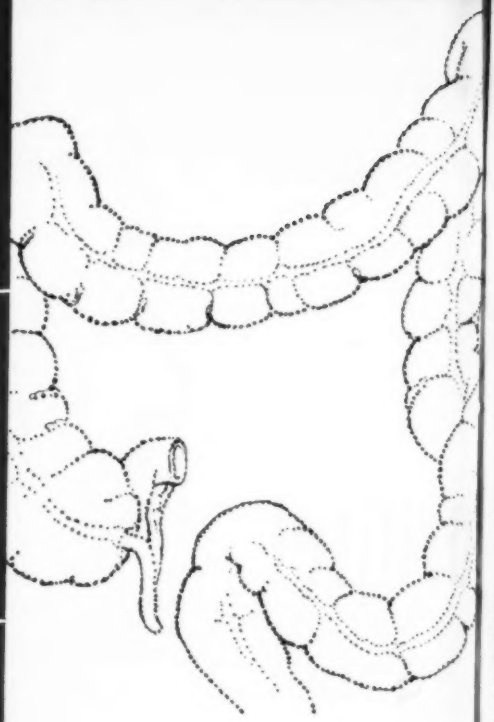
available in two forms:

'Drilitol Spraypak' and 'Drilitol' Solution

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.
†T.M. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide, S.K.F 'Spraypak' Trademark





Roentgenographic pattern of colon mass propulsion:[1]

"The haustral markings suddenly disappear, the bowel appearing radiologically as a solid unsegmented column. A strong and rapid peristaltic wave then travels over the transverse and descending colons carrying all before it. The haustral markings then reappear. The contents of the more proximal portion of the colon are thus transferred to the pelvic colon which becomes filled from below upwards."[1]

(1) Ascending colon filled.

(2) Unsegmented mass propelled through transverse colon.

(3) Propulsive force follows mass through descending colon.

(4) Pelvic colon reservoir filled.

SMOOTHAGE ACTION IN CONSTIPATION

Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.[2]

Reestablishing Bowel Reflexes with Metamucil®

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of Plantago ovata) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

Contributing Factors

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.[2]

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, nonirritating and nonallergenic.

Dosage Considerations

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. G. D. Searle & Co., Research in the Service of Medicine.

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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

SEARLE

the patient—and to collect cash after every visit.

I did this with some trepidation. But it has worked out well. Though many patients left me, a new variety took their place. They demand more attention but they're willing to pay for it.

I no longer employ a full-time bookkeeper. And I can keep my mind on my work, without wondering when and if I'm going to be paid.

M.D., California

Black Sheep

SIRS: I agree with the view expressed in one of your editorials: that a medical society accomplishes little by expelling an unethical doctor. If he's expelled, he's in exactly the same position as the doctor who refused to join the society in the first place.

Only the state examining boards can take effective disciplinary action against medicine's black sheep —if they only would.

Creighton Barker, M.D.
New Haven, Conn.

Office Laboratories

SIRS: I commend Ben L. Loventhal, author of "Does a Laboratory Technician Pay Off?" for his objective approach to the problems of running an office laboratory. But I feel that some of the ideas expressed in his article may be harmful.

[MORE▶

TYPICAL SANKA BOOTH AT MEDICAL CONVENTIONS ALL OVER THE COUNTRY

YOU PRAISED ITS RICH, FULL FLAVOR

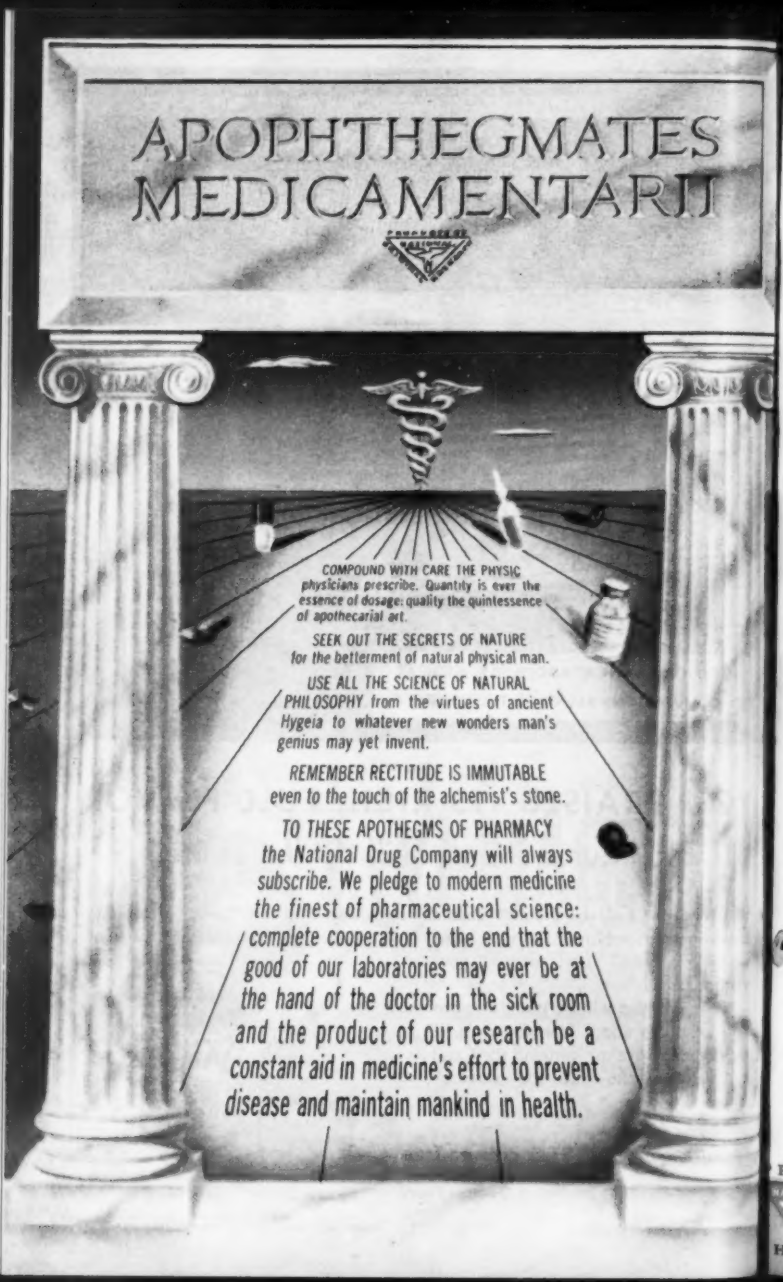
. . . your patients will do the same!

"Delicious! Full-bodied!" That's how you described Instant Sanka Coffee when you tasted it at medical conventions.

Your patients will be grateful when you tell them about Instant Sanka. If they're sensitive to caffein, they can still drink all the coffee they want by switching to Instant Sanka, because it's pure coffee with the caffein taken out.

All pure coffee . . . 97% caffein-free

Product of General Foods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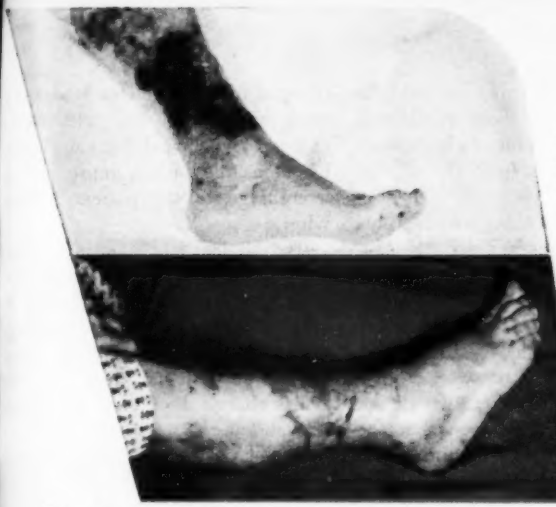
COMPOUND WITH CARE THE PHYSIC physicians prescribe. Quantity is ever the essence of dosage; quality the quintessence of apothecarial art.
SEEK OUT THE SECRETS OF NATURE for the betterment of natural physical man.
USE ALL THE SCIENCE OF NATURAL PHILOSOPHY from the virtues of ancient Hygeia to whatever new wonders man's genius may yet invent.
REMEMBER RECTITUDE IS IMMUTABLE even to the touch of the alchemist's stone.
TO THESE APOTHEGMS OF PHARMACY the National Drug Company will always subscribe. We pledge to modern medicine the finest of pharmaceutical science: complete cooperation to the end that the good of our laboratories may ever be at the hand of the doctor in the sick room and the product of our research be a constant aid in medicine's effort to prevent disease and maintain mankind in health.



Female diabetic, 72 years old. Peripheral arteritis obliterans, with cellulitis and gangrenous ulcerations. Burning pain.

Time between photos 9 weeks.

Parenzyme administered daily. Healing of ulcer complete. Pain and edema eliminated.

Established Traumatic Vascular Therapy

In decay processes of vascular inflammatory origin with burning pain, swelling and cellular necrosis, Parenzyme's direct proteolytic action alters the chemical and enzymatic phase of circulatory stasis. The integrity of the local circulation is re-established permitting all physiologic processes of repair to proceed unimpeded.

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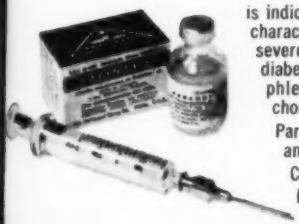
INTRAMUSCULAR TRYPSIN



is indicated in a wide range of inflammatory disorders characterized by edema, such as slow-healing wounds, severe bruises, contusions, black eyes, decubitus, diabetic and varicose skin ulcers, phlebitis, thrombophlebitis, phlebothrombosis, iritis, iridocyclitis, chorioretinitis.

Parenzyme is safe and has no anti-coagulant effect, and is compatible with antibiotics.

Clinical and experimental evidence of Parenzyme's potent therapeutic action has been established in over 16 scientific published papers. Reprints are available upon request.

The film "CLINICAL ENZYMOLOGY" is now available for showing at medical meetings upon your request. And be sure to watch for the MED-AUDIOGRAPHS, a series of recorded clinical discussions.

PRODUCTS OF ORIGINAL RESEARCH

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THE NATIONAL DRUG COMPANY PHILADELPHIA 44 PA.

For example, Mr. Loventhal tells us that "fortunately" one small-town G.P. "was able to hire [a laboratory technician] away from the nearest hospital."

Now, any physician is free to outbid a hospital for the services of a technician. But it's clear that he thereby removes a practicing medical technologist—of whom there are all too few—from a service in which she contributed to the welfare of a maximum number of patients. And my experience has been that the physician who hires such a technician is often the first to complain that hospital laboratories aren't as efficient as they should be.

Another point: Though the fees charged by the G.P. for laboratory work may be in line with those charged by clinical laboratories in his area, they often represent an overcharge to the patient. Here's why:

The clinical laboratory's fee usually covers the supervising pathologist's investment in his training. If the G.P. has had no special training, he can't give the supervision that a clinical pathologist does. So the G.P.'s charge should be lower than the laboratory's.

M.D., Indiana

SIRS: The doctor should make spot checks on his technician's work *regularly*—not just while she's learn-

treat her ACNE, too

When teen-agers come to you for any reason—treat that acne, too.

They may be too self-conscious to seek your advice but—to prevent permanent scarring—their acne demands early treatment under your skilled supervision.

ACNOMEL* CREAM

the most widely prescribed acne preparation

- brings rapid improvement, often in days
- quickly lifts patients' morale, gains their cooperation
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- is virtually invisible when applied
- contains sulfur-resorcinol-hexachlorophene in a special grease-free vehicle

Also available: 'ACNOMEL' CAKE (½ strength) for convenient daytime application, in school or at work.

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*T.M. Reg. U.S. Pat. Off.

it's a rare child* who doesn't

*

(and he's taking ABDEC Kapse

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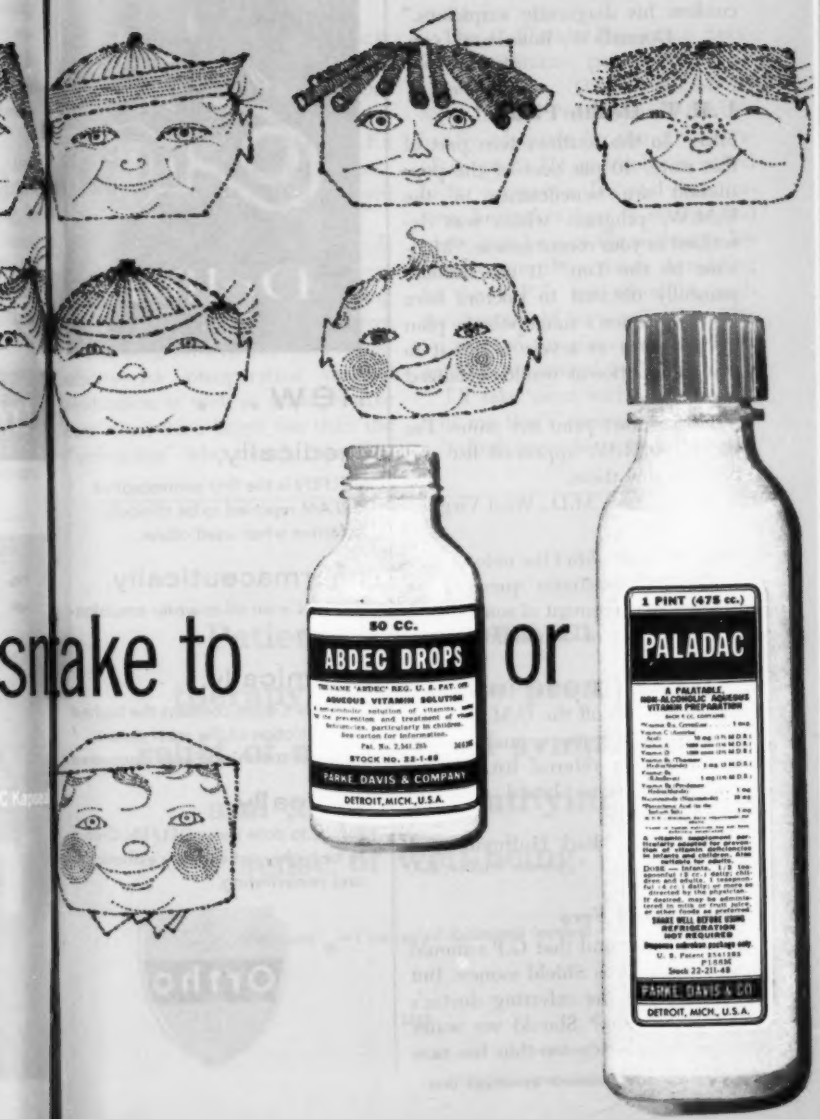
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AQUEOUS VITAMIN SOLUTION
for the prevention and treatment of vitamin deficiencies, particularly in children.
See carton for information.
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PARKE, DAVIS & COMPANY
DETROIT, MICH., U.S.A.
or
1 PINT (475 cc.)
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A PALATABLE, NON-ALCOHOLIC AQUEOUS VITAMIN PREPARATION
A vitamin supplement particularly adapted for prevention of vitamin deficiencies in infants and children. Also tonic for adults.
Dose — Infants, 1 teaspoonful (5 cc.) daily; 100-pound (45 kg.) boy, children and adults, 1 teaspoonful (4 cc.) daily or more as directed by the physician. If desired, may be administered in milk or fruit juice, or other foods as preferred.
SHAKE WELL BEFORE USING
REFRIGERATION NOT REQUIRED
Dispense in original package only
U. S. Patent 2,161,285
PARKE, DAVIS & CO.
DETROIT, MICH., U.S.A.

ing, or when "her test results don't confirm his diagnostic suspicions."

Donnell W. Boardman, M.D.
Maynard, Mass.

U.M.W. Health Plan

SIRS: In the southwestern part of this state, 40 per cent of the population are beneficiaries of the U.M.W. program, which was described in your recent article, "Medicine by the Ton." It has become painfully obvious to doctors here that the union's monopolistic plan poses almost as severe a threat to private practice as would socialized medicine.

Please don't print my name. I'm on the U.M.W. approved list and want to stay there.

M.D., West Virginia

SIRS: Why *shouldn't* the union's area medical administrator question the doctor's management of some cases? Isn't that part of an administrator's job?

And what if some board men *have* been left off the U.M.W.'s approved list? I know a number who aren't on *my* referral list. It's no secret that some board men are poor doctors.

Park Huffman, M.D.
South Whitley, Ind.

Blue Shield Fees

SIRS: It's natural that G.P.s should want more Blue Shield money. But where could the referring doctor's fee come from? Should we water down the already-too-thin fee now

being paid the surgeon? If not, we'd have to raise the premium rates.

Blue Shield is owned lock, stock, and barrel by the medical societies. And most such societies have more G.P. members than surgeons. If the situation were as bad as the G.P.s say, they could change the system.

M.D., New Jersey

SIRS: Your articles and editorials on the surgical fee debate appear to indicate that one solution is being sought for two different problems.

The surgeon who accepts responsibility for preoperative surgical evaluation as well as postoperative care deserves a larger fee than the "technician" who merely operates. Yet this fee distinction is seldom made.

The California Physicians' Service, for instance, pays $105 for an appendectomy. This is probably all right for the "technician." But it's hardly adequate for the other type of surgeon. He generally is called in for a home or hospital consultation; he makes four to six hospital visits; and he sees the patient in his office two or three times. According to the C.P.S. fee schedule, such services would be worth some $60. So the fee for the operation itself amounts to around $40.

I'll take issue with anyone who tells me that's excessive!

I think every fee schedule should

include an extra payment for pre- and postoperative care—$50, say, for appendectomy cases. Thus, in California, the "technician" surgeon would bill for $105; the other type of surgeon would bill for $155.

The single-standard surgical fee schedule pleases no one but low-premium health insurance carriers. Let's try the double standard.

Edward K. Strong, M.D.
San Francisco, Calif.

SIMS: Because of the difference in fees and incomes in rural and urban areas, I believe we're a long way from a standard contract paying uniform fees throughout the country . . .

If urban-type contracts are introduced in rural areas, they immediately raise the cost of medical care for most people. For example, a large company that dominated a community in the southern part of this state was long enrolled in our Blue Shield program. The maximum fee was $200, with $100 for an appendectomy and $35 for a tonsillectomy. Then, three years ago, the company switched to a commercial plan that pays $175 for an appendectomy and $60 for a tonsillectomy. Immediately, costs of medical care increased to this level for everyone in the community.

R. S. Saylor
Mutual Medical Insurance, Inc.
Indianapolis, Ind.

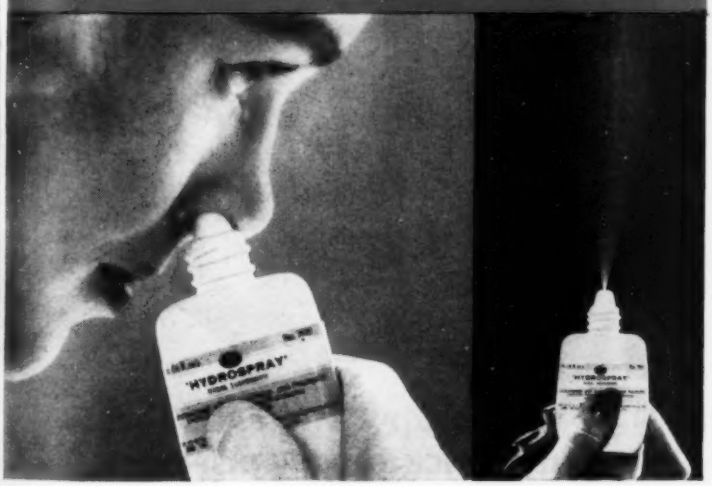
END

'Hydrospray' NASAL SUSPENSION

(HYDROCORTONE® WITH PROPADRINE® AND NEOMYCIN)

Anti-inflammatory— Decongestant—Antibacterial

MAJOR ADVANTAGES: New synergistic anti-inflammatory, decongestant and antibacterial formula. High steroid content assures effective response.



Topically applied hydrocortisone[1] in therapeutic concentrations has been shown to afford a significant degree of subjective and objective improvement in a high percentage of patients suffering from various types of rhinitis. HYDROSPRAY provides HYDROCORTONE in a concentration of 0.1% plus a safe but potent decongestant, PROPADRINE, and a wide-spectrum antibiotic, Neomycin, with low sensitization potential. This combination provides a three-fold attack on the physiologic and pathologic manifestations of nasal allergies which results in a degree of relief that is often greater and achieved faster than when any one of these agents is employed alone.

INDICATIONS: Acute and chronic rhinitis, vasomotor rhinitis, perennial rhinitis and polyposis.

SUPPLIED: In squeezable plastic spray bottles containing 15 cc. HYDROSPRAY, each cc. supplying 1 mg. of HYDROCORTONE, 15 mg. of PROPADRINE Hydrochloride and 5 mg. of Neomycin Sulfate (equivalent to 3.5 mg. of neomycin base).

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* **60**:431, Oct. 1954.

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—SEAMLESS PLASTIC BANDAGES IN NEW "PICK-QUICK" DISPENSER

Seamless Stick-Dots and Stick-Patches are packaged for easy, convenient use, as above. Stickbands come in handy wall or desk dispensers.

Pliable, plastic backing and firm adhesive mass are quality features of these outstanding bandages by Seamless. They contain *fatty acid salts, zinc propionate* and *zinc caprylate* which minimize itching and irritation. The nearest approach to skin in a bandage, they won't slide or skid. Packaged 100 to a box. Please order through your Surgical Supply Dealer.

SURGICAL DRESSINGS DIVISION

THE SEAMLESS RUBBER COMPANY

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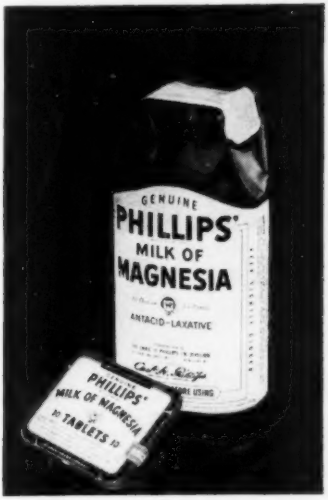
An Ideal Antacid-Laxative



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In every field there are a very few products whose quality and demonstrated dependability over many years give them a position of pre-eminence over all others. It is this dependability which inspires confidence and universal acceptance of Phillips' Milk of Magnesia. Known and prescribed throughout the world for over 75 years.

PREPARED ONLY BY THE CHAS. H. PHILLIPS CO. DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.

Efficient milk replacement

for the milk-allergic infant

Practical equivalent of milk

Gerber Meat Base Formula closely approximates evaporated milk in complete proteins, carbohydrates, fats and minerals. To be fed through regular nursing bottles.

Well tolerated by infants

Clinical studies* indicated "infants accepted meat base formulas well. Fewer patients were sensitive to meat than legumes." Incidence of digestive upsets low.

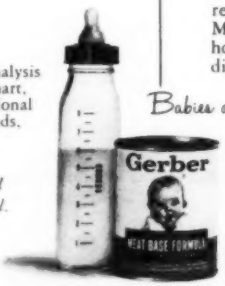
Normal growth and development assured

Authoritative report* substantiated the nutritional superiority of meat proteins over legume proteins. No instances of weight loss or anemia in over 100 infants receiving Meat Base Formula were disclosed.

Desirable allergy determinant

When milk allergy is suspected, replace milk feedings with Gerber Meat Base Formula for 48 to 96 hours. Improvement will confirm diagnosis.

For Meat Base Formula analysis and feeding instruction chart, write to: Dept. of Professional Services, Gerber Baby Foods, Fremont, Michigan.



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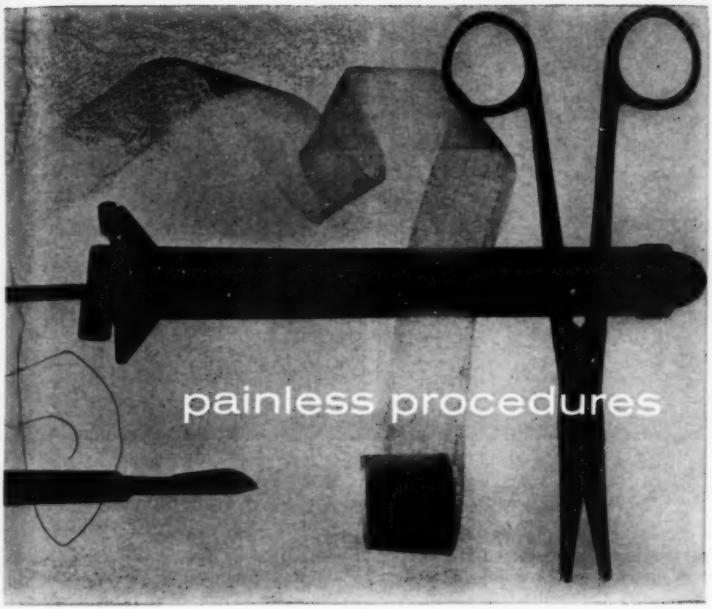
**Rowe, Albert, Jr., M.D., and Rowe, Albert H., M.D.: Cal. Med. 81:279 (Oct.) 1954*



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Prompt and protracted topical anesthesia for the control of pain and itching in dermatitis, office surgery, anorectal disorders, mucocutaneous lesions, burns, and abrasions.

Ointment, 1%, in 1-ounce tubes and rectal applicator; 1-pound jars for office use.
Cream, 0.5%, in 1¼-ounce tubes.
Ophthalmic Ointment, 0.5%, in ophthalmic-tip tubes of 4.0 Gm. each.

Nupercainal® ointment (dibucaine ointment CIBA)
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from disability to dexterity

Acetycol brings welcome relief quickly to the patient suffering from arthritis and related rheumatoid diseases. As Acetycol increases the range of pain-free movement, the patient, freed from the twin taskmasters of pain and rigidity, is able to resume many of his normal activities.

The sustained effect of Acetycol is based on the relationship between aspirin and para-aminobenzoic acid. A relatively low dosage of aspirin produces high salicylate blood levels in the presence of PABA. The effectiveness of Acetycol in gout or cases of a gouty nature is due to the inclusion of salicylated colchicine.

Acetycol also contains three important vitamins, often lacking in older and rheumatic patients: ascorbic acid, to prevent degenerative changes in connective tissues; thiamine and niacin, for improved carbohydrate utilization and relief of joint pain and edema.

Usual dosage – 1 or 2 tablets three or four times a day.

Each Acetycol Tablet contains:

Aspirin	325.0 mg.
Para-aminobenzoic acid	162.0 mg.
Colchicine, salicylated	0.25 mg.
Ascorbic acid	20.0 mg.
Thiamine hydrochloride	5.0 mg.
Niacin	15.0 mg.

Supplied: Bottles of 100 and 500

Acetycol

TRADEMARK

to relieve rheumatic pain

WARNER-CHILCOTT

Now from Bauer & Black

the first 51 gauge elastic stockings

Here at last are elastic stockings your patients will take to cheerfully. 51 gauge, made with threads twice as thin and twice as light as former kinds. So sheer they make "overhose" a thing of the past. Full-fashioned like regular nylons.

Yet, sheer as they are, Bauer & Black's 51 Gauge Elastic Stockings provide proper remedial support. Pressure decreases gradually from the ankle up, gently speeding venous flow.

New full-footed style

These full-footed stockings can be worn all day, every place your patient may go. Heel and toe are non-elastic, made with Helanca® stretch nylon to prevent cramping or binding.

To be *sure* of patient cooperation, doctor, aren't these the elastic stockings to prescribe?

Of course, you and your patients can still choose from the complete Bauer & Black line: nylon or cotton . . . open toe or closed toe . . . knee length, above knee or extra long . . . variety of prices.

51 Gauge Elastic Stockings

BAUER & BLACK

Division of The Kendall Company
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Editorials

Time for a hard decision on Social Security • The best sort of bonanza for medical schools • Is hospital practice on the way out? • Blue Shield for doctors • Who sets fees? • The story behind a 'clique'

Social Security Mirage

A lot of doctors have been thinking they may soon be able to get *voluntary* coverage under Social Security. But according to Marion B. Folsom, who should know, optional Social Security for physicians is out of the question.

"It's not actuarially sound," says the Secretary of Health, Education, and Welfare.

More than that, it's not politically likely. "Never in a million years would Congress pass a bill giving this special privilege to self-employed physicians," one influential Congressman has remarked privately.

On the other hand, Congress hesitates to thrust *compulsory* coverage on the medical profession. "If doctors choose to remain excluded," says Secretary Folsom, "I have some doubts whether they will be forced in against their will."

This leaves the decision squarely up to you. You can get compulsory coverage, if you want it, or you can get nothing at all. There's pretty clearly no middle course.

If you haven't already done so, you'll soon be voting in various Social Security polls. A few state medical societies held such polls last year; most of the rest will be holding them soon, at the A.M.A.'s request. And in April this magazine hopes to include a question on Social Security in its quadrennial survey of the entire professi n.

These votes will be meaningful only if the mirage of voluntary coverage is banished both from the pollsters' ballots and from the doctors' minds.

Medical-School Bonanza

The country's medical schools are still reeling under the impact of the largest single present they've ever been given: the $90 million lump-sum grant from the Ford Foundation.

At this writing, some details are still unclear to the schools. But these facts stand out:

How you can shorten convalescence in adults

While 'Trophite' was developed to increase appetite in below-par children—and thus increase growth—it has also proved extremely useful in convalescent adults.

That is because 'Trophite' not only improves appetite but also promotes the proper utilization of food. Studies with B_{12} emphasize "the importance of adequate supplies of this vitamin in the metabolism of carbohydrate and fat, including not only the conversion of carbohydrate to fat, but the metabolism of fat itself." (Editorial, J.A.M.A. *153*:960)

In addition to B_{12}, 'Trophite' contains B_1 whose value in combating anorexia is established. Try 'Trophite' in your next convalescent—and see how quickly he is up and about. 'Trophite' is available both as tablets and as a truly delicious liquid. Each tablet or teaspoonful (5 cc.) supplies: 25 mcg. B_{12}, 10 mg. B_1.

the high potency combination of B_{12} and B_1

Trophite* *for* appetite

*T.M. Reg. U.S. Pat. Off. *Smith, Kline & French Laboratories, Philadelphia*

¶ The entire amount is being channeled to privately supported medical schools—a total of forty-two.

¶ These schools will thus get an average grant of about $2 million apiece—though some grants may range up to $5 million and others may be $1 million or less.

¶ The entire sum will be put into endowment funds and the interest used to raise faculty salaries. An estimated 4 per cent return will produce $3.6 million a year—which amounts to *over one-third* of the $10-million-a-year private help that medical schools seek. (By comparison, the National Fund for Medical Education raised $2.5 million last year.)

Here is private philanthropy at its best. The Ford Foundation, offspring of a great corporation, has joined forces with thousands of individual contributors to meet a common goal. This is the sort of teamwork that may yet make intervention by the Government unnecessary.

Is Hospital Practice Out?

For years there's been a hot dispute as to whether hospitals can legally hire doctors on salary, then collect fees from their patients. State attorney generals have given conflicting opinions. The controversy has been endless. And hospitals have gone right on treating their pathologists and radiologists as salaried employes. [MORE ▶

BACK ON HIS FEET BUT STILL SICK.....

...he Problem of Residual Anemia

in Upper Respiratory and Other Infections

...he persistent anemia which you so ...requently see in association with an ...fectious process demands serious con...ideration since it "favours the develop...ent of further infection and may re...ard convalescence."[1]

Noteworthy is the slow recovery of ...he anemic patient following viral or ...acterial upper respiratory involve...ent.

Cobalt appears to be the only known ...gent capable of stimulating the de...ressed bone-marrow function typical ...f post-infection anemia.

...NCOVITE® presents the original, clini...ally proved, pure cobalt-iron product. ...horough investigation has verified the ...ffectiveness and safety of Roncovite.

Continuing Clinical Proof of Effectiveness in Anemia Associated with Infection

"Cobalt appears to be a valuable drug in the treatment of anemias secondary to chronic diseases."[2]

"The marked increase in the early erythroid cells in the [children]...with anaemia of infection point to a direct stimulation of the erythroid tissue of the marrow as the main action of the cobalt."[1]

" . . . [cobalt] will force the bone marrow to make more cells even when nephritis or chronic infection are the causes of the anemia."[3]

"There is no doubt that given in sufficient dosage . . . [cobalt] is effective in alleviating the anemia secondary to infection, cancer, and renal disease."[4]

"In our hands, cobalt appeared to be a useful and valuable drug, well tolerated and devoid of undue toxicity."[2]

RONCOVITE®

...UPPLIED:

...oncovite Tablets—red, enteric ...oated in bottles of 100. Ron...ovite-OB—red, capsule-shaped ...ablets in bottles of 100. Ron...ovite Drops—bottles of 15 cc. ...ith calibrated dropper.

DOSAGE:

One tablet after each meal and at bedtime. Children, 1 year or over, 0.6 cc. (10 drops); infants less than 1 year, 0.3 cc. (5 drops) once daily diluted with water, milk or fruit juice.

REFERENCES:

1. Coles, B. L.: Arch. Disease in Childhood *30*:121 (April) 1955.
2. Weinsaft, P. P., and Bernstein, L. H. T.: Amer. J. Med. Sc. *230*:264 (Sept.) 1955.
3. Vilter, R. W.: Amer. J. Clin. Nutr. *3*:72 (Jan.-Feb.) 1955.
4. Cartwright, G. E.: Amer. J. Clin. Nutr. *3*:11 (Jan.-Feb.) 1955.

But now all that's subject to change. In a major court decision, Judge C. Edwin Moore has ruled flatly that—in Iowa, at least—the custom is illegal. It's the corporate practice of medicine, he says.

This ruling should give most hospital boards cause for deep and careful reflection. What was only talk for so long has at last resulted in action.

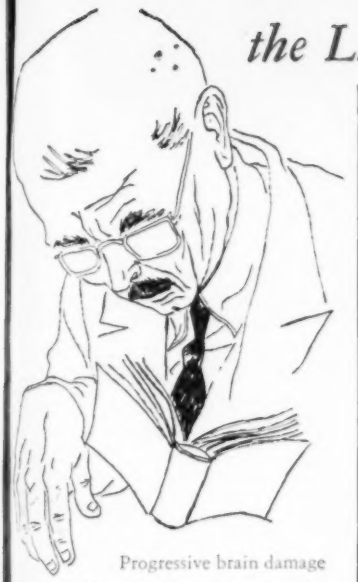
Barring a successful appeal, Judge Moore's decision will have the force of law in Iowa—thus bringing an end to salaried practice in Iowa's hospitals. And, as a legal precedent, it may well mark the beginning of the end of such practice in other states. Perhaps even in *your* state—if you and your colleagues press the issue as resolutely as it was pressed in Iowa.

An Old Custom Made New

An insistence on giving service without charge is one of the ennobling customs of our profession. We'd hate to see this ancient custom—or the deep love of profession that motivates it—die out.

It frequently collides, however, with a broader and equally insistent social custom. This is the sending of gifts to show gratitude. All men, not just doctors, feel an urge to repay debts of kindness in some tangible way. [MORE▶

the Little Stroke



Progressive brain damage is most frequently associated with arteriosclerosis and capillary fragility often resulting from a variety of causes.

These include long standing hypertension; chronic renal disease whether due to glomerulonephritis, nephrosclerosis, chronic pyelonephritis. In long standing diabetics, this condition is noted in a certain percentage of patients with Kimmelstiel-Wilson Syndrome. Although the primary disease is very different in these various entities, the final pathological findings are remarkably similar, capillary fragility.

Whenever the ophthalmoscopic examination reveals hemorrhagic areas, it is reasonable to assume a comparable process is going on in the brain.

Clinical evidences of this deterioration are manifested by: reduced intellectual activity, mental confusion, impaired judgment, emotional instability, listlessness, loss of appetite, weakness and early fatigability.

What we have described are symptoms of senility. Cerebral arteriosclerosis and capillary fragility have always been a difficult problem. The addition of Hesper-C to the diet of the elderly with the above indications makes the difference in capillary strength.

HESPER-C

is the original synergistic nutritional supplement for capillary integrity and provides 100 milligrams each of Ascorbic Acid and Hesperidin concentrate.

Send for samples and reprints.

The film "CLINICAL ENZYMOLOGY" is now available for showing at medical meetings upon your request. And be sure to watch for the Med-Audiographs, a series of recorded clinical discussions.

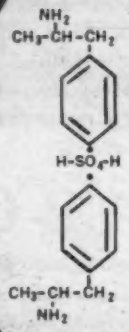
PRODUCTS OF ORIGINAL RESEARCH

THE NATIONAL DRUG COMPANY PHILADELPHIA 44, PA.

1938

first, amphetamine

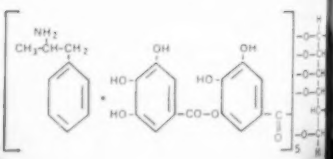
1945



then,
dextro-
amphetamine

1956

and now tanphetamin
protocolloid complex



now... incorporating the first basic d-amphetamine improvement in 10 years

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1 dose a day for all-day control of your patients

2 tabules at 10 a. m.

Synatan introduces an entirely new principle of sustained *d*-amphetamine release . . . by simple principles of physical chemistry . . . *completely independent of any particular gastrointestinal pH*. Synatan does not depend upon coatings of any kind for its unique, prolonged and smooth action.

Synatan T.M.

brand of tanphetamin protocolloid complex, Irwin-Neisler

- One dose a day for all day control of your patients
- No peaks or valleys . . . no sudden bursts of activity
- Better results . . . fewer side effects . . . *and Synatan saves money for your patients*

Each Synatan tabule is composed of a protocolloid complex containing tanphetamin (*d*-amphetamine tannate) 17.5 mg., equiv. to 5.25 mg. of *d*-amphetamine base. Bottles of 50 and 500 tabules.

IRWIN, NEISLER & COMPANY

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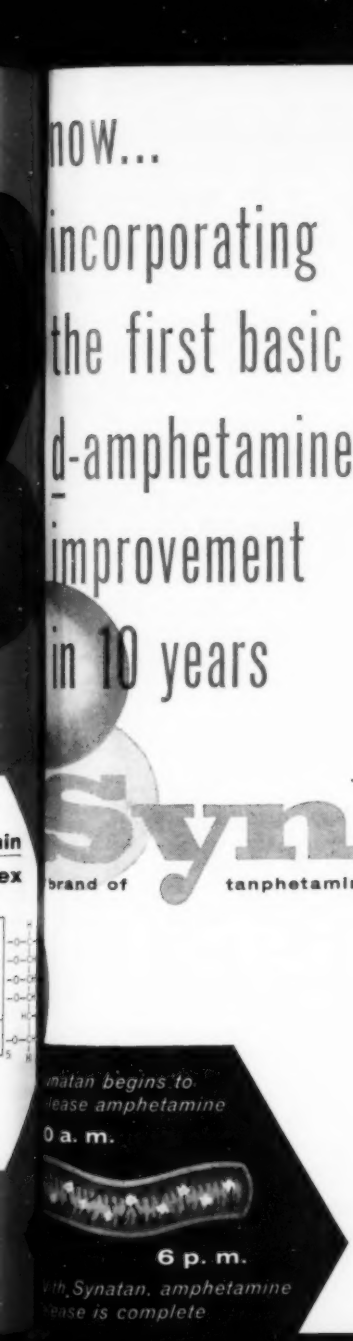


But the urge—even the necessity—to repay is especially acute for physicians. After every operation, childbirth, or serious illness in a physician's family, someone must go gift hunting. Someone must find the family doctor (or family specialist) a present that's impressive enough to show real regard for the service given, but that's still not so extravagant as to be unacceptable.

As for the physician who gets the presents, he and his wife inevitably wind up with a houseful of desk sets, statuettes, silver trays, and other valuable but progressively useless junk. He (secretly) and she (openly) would often gladly trade the whole lot for $50 in cash to buy something they *really* want.

This is now possible, in a manner of speaking. It's simply a matter of the doctors' joining Blue Shield. Blue Shield membership spares the M.D. patient from the gift-sending routine. And it automatically provides a bit of cash for the man who treated him.

The A.M.A. Judicial Council recently reaffirmed the ethics of intramedical Blue Shield. The House of Delegates added *its* stamp of approval last December. And in an article last month, this magazine indicated how to go about actually setting the plan in motion.

[MORE ▶

because
your allergic patients
need a lift
a new R_x...

Plimasin®

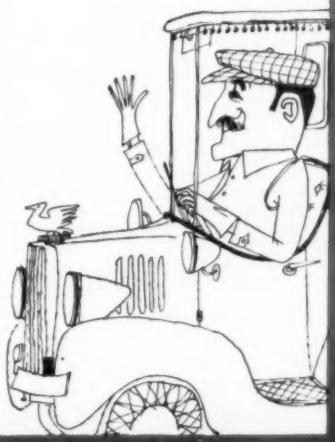
(tripelennamine hydrochloride and methyl-phenidylacetate CIBA)

new, mild stimulant
and antihistamine

boost their spirits... relieve their allergic symptoms

So often the allergic patient is tired, irritable, depressed—mentally and physically debilitated. Frequently, antihistaminic agents themselves are sedative, adding to this already fatigued and disconsolate state.

Plimasin, because it combines a proved antihistamine with a new, mild psychomotor stimulant, overcomes depression and fatigue while it achieves *potent* antiallergic effects. Its new stimulant component—Ritalin—is totally different from amphetamine: smoother, gentler in action, devoid of pressor effect.



DOSAGE: *One or 2 tablets as required.*

Each Plimasin tablet contains 25 mg. Pyribenzamine® hydrochloride (tripelennamine hydrochloride CIBA) and 5.0 mg. Ritalin® (methyl-phenidylacetate CIBA).

CIBA SUMMIT, N. J.

2/2191M

The most successful antibiotic in the most appealing form

PENICILLIN

"...in the spectrum of infectious diseases responding to antibiotic therapy...71.8 per cent...are most successfully treated with penicillin. Only 7.4 per cent require the broad-spectrum antibiotics."

—Krantz, J. C.:
Pennsylvania M. J., 58:383 (April) 1955.

DRAMCILLIN

penicillin in the most appealing—oral—form. All Dramcillin liquids are delicious. Dramcillin is potassium penicillin G—the ideal oral penicillin salt for high initial peaks and prolonged blood levels.

Blue Shield was founded *by* doctors. There's no reason why it shouldn't work *for* doctors.

Who Sets Fees?

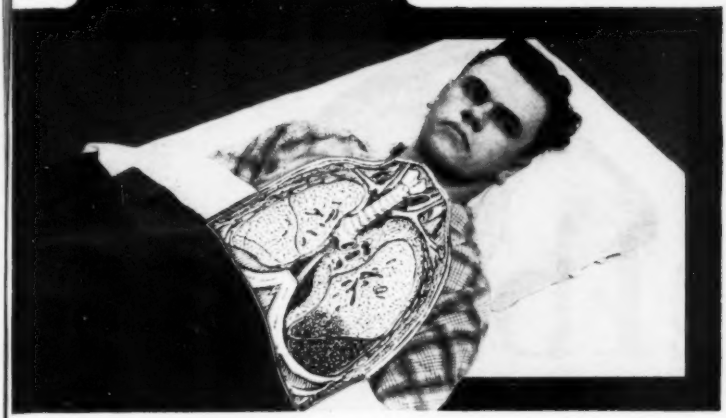
Are you delivering babies in Kansas City? You should charge $100 per delivery. Do you set fractured arms in Denver? You should charge $50 per arm. Do you make house calls in Albany, N.Y.? You should charge $5. So says the magazine Redbook.

Last month it listed specific fees for office calls, house calls, and ten common medical or surgical procedures in cities across the U.S. Above the list appeared the big, black headline: WHAT YOUR DOCTOR SHOULD CHARGE.

Such a listing is both misleading and absurd. It ignores the *range* of fees in any medical community. It ignores the *right* of any physician to charge more than the average fee or less than the average fee, as he thinks proper.

Some medical communities have voluntarily narrowed the range of their fees, have voluntarily restricted their right to charge extra. They've done this to promote better public understanding of fees—and better health insurance coverage. But any "usual fee" plan like this must come from the doctors themselves. It cannot be imposed

ANATOMY OF DISEASE



FOUR SULFAS FOR GREATER CERTAINTY

safety • rapid action • broadest antibacterial spectrum

DELTAMIDE®

THE PREFERRED QUADRI-SULFA MIXTURE

Deltamide combines four sulfas for a better therapeutic effect and remarkable freedom from toxicity. Deltamide assures:

- **effective blood levels in most patients within an hour**
- increased solubility in the urine • low incidence of sensitization
- broadest spectrum of antibacterial activity

Each Deltamide tablet or 5 cc. teaspoonful of good-tasting suspension supplies:

Sulfadiazine	0.167 Gm.
Sulfamerazine	0.167 Gm.
Sulfamethazine	0.056 Gm.
Sulfacetamide	0.111 Gm.

Tablets:
Bottles of 100 and 1000.

Suspension:
4 and 16 oz. bottles.

WHEN THE SITUATION CALLS FOR SULFONAMIDES WITH PENICILLIN—

PRESCRIBE DELTAMIDE *w/penicillin*

Each tablet or 5 cc. of the suspension also contains 250,000 units of potassium penicillin G.

THE ARMOUR LABORATORIES

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complete
2-a day
therapy for
the anemias

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Iberol® is

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2 IBEROL FILMTABS SUPPLY:

the right amount of iron

Elemental Iron .....210 mg.
(as Ferrous Sulfate)

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anti-pernicious anemia activity

BEVIDORAL® ..1 U.S.P. Oral Unit
(Vitamin B_{12} with Intrinsic Factor Concentrate, Abbott)

+

essential nutritional factors

Folic Acid	2 mg.
Ascorbic Acid	150 mg.
Liver Fraction 2, N.F.	200 mg.
Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	3 mg.
Pantothenic Acid	6 mg.

Abbott

In bottles of 100, 500 and 1,000 *Filmtabs.*

on them without their knowledge and consent—especially by a lay publication.

Some of the figures that Redbook used (or misused) were taken from this magazine; and legal counsel is now investigating the apparent violation of our copyright.

We are not, incidentally, telling our lawyer what he should charge for his services. Perhaps the next issue of Redbook will.

Cliques Don't Have to Be

The complaint is sometimes heard that organized medicine is undemocratic. One medical society or another is said to be ruled by a clique or an entrenched minority, or bossed by a handful of leaders.

How does a society get into this situation? Well, let's take a look at a typical case—one example among many:

The New Jersey Academy of General Practice has 369 active members. Late last year the Academy held its annual business and clinical meeting in Newark. It was a popular gathering: Between 300 and 400 physicians (about two-thirds of them member G.P.s) came to hear the clinical papers that afternoon.

Yet how many bothered to attend the business meeting held just previously? How many thus had a share in electing this year's officers and in determining this year's policy?

About twenty. END

How Nonprofit Are Our Nonprofit Hospitals?

By Robert M. Cunningham Jr.

Some of them run up huge surpluses, but most barely break even. They'd be definitely in the red if they took proper account of depreciation

• Are nonprofit hospitals really nonprofit?

Administrators and trustees, who have to pay the bills, insist that they are. But some doctors see huge receipts coming into diagnostic service departments. They know these departments don't spend all they earn. So they question whether "nonprofit" is an accurate description for such hospitals.

So do many patients confronted with hospital bills that range from $20 to $40 per day, or even more.

What are the facts?

Unquestionably, some hospitals *do* make profits. For example, about 4 per cent of U.S. hospital beds are in proprietary hospitals. Nobody except the owners—and Federal income tax authorities—knows how much these hospitals make. But you can get some idea from the experience of one Los Angeles hospital. It started with just twenty beds right after World

THE AUTHOR *is editor of The Modern Hospital.*

War II. Today it has over 100 beds. "The additions were built out of operating profits," says a report from Los Angeles.

Some so-called nonprofit hospitals have had a comparable experience:

¶ A California hospital completed an addition that included fifty beds and a new diagnostic service department without borrowing or raising a penny by public subscription.

¶ A Chicago hospital retired a debt of $1 million in seven years of postwar operation.

¶ The administrator of a $4½ million hospital in a midwestern town recently commented that his hospital was in excellent shape financially. "We borrowed $1½ million to complete the building," he said, "but we're paying that back out of earnings. We don't need money."

¶ A 100-bed suburban hospital in an eastern state recently published its financial statement, showing a net "profit" of $97,000 on a total operating budget of $1,100,000.

Can these hospitals properly be considered "nonprofit"?

It all depends on what we mean by the term.

If any surplus of income over expenditures is called "profit," then obviously these and hundreds of other hospitals are making profits—many of them sizable profits.

But as the term "nonprofit" is commonly used among hospital people, it means simply that no part of such surplus funds may be pocketed by any individual. In the phraseology of most nonprofit hospital charters, and of the state laws under which these charters are granted to nonprofit corporations: "No part of the income from such corporation shall inure to the benefit of any individual."

By this definition, a hospital can earn a million-dollar surplus in five years, apply it on a building debt or even put it in the bank, and still be a nonprofit hospital.

Red-Ink Record

Relatively few hospitals actually earn such surpluses. According to the American Hospital Association, the *average* voluntary general hospital last year had an earned income (collected from patients or from Blue Cross, insurance companies, and other agencies in behalf of patients) of $21.07 per patient day.

Its total expenses came to $22.78 per patient day. Operating loss: $1.71 per patient day.

Happily, the average hospital is still regarded as a charitable institution. As such, it is the beneficiary of individual and corporate philanthropy. It also draws income from endowments provided by philanthropists in years past. Total income from these "other sources" averaged $2.24 per patient day, or 53 cents *more* than the operating deficit.

The Hidden Cost

In most hospitals, the narrow margin between profit and loss is bridged by a single item: depreciation on plant and equipment. American Hospital Association statistics do not show this detail. But one hospital accounting authority has estimated that, on the average, depreciation charges amount to $1.20 to $2.10 per patient day.

This depreciation charge is not usually reported as an operating expense. If it were, the figures would show a net loss, instead of a surplus, for the average hospital.

"We are wearing out our buildings in service to the community," is the way one board president expresses this hidden-ball trick in hospital finance.

Some hospitals *do* charge depreciation on plant and equipment as an operating expense. A few of these fund the depreciation account, banking a check every month against future needs for plant expansion and new equipment. This is good business practice. But it is not the common practice among hospitals.

Generally speaking, hospital authorities divide on the question of depreciation according to whether they were trained in business or grew up in the hospital field.

The first group—a small but growing minority—feels the hospital, like business, should charge and collect for depreciation and stand on its own financial feet.

Generosity Fades

The older, and still prevailing, opinion is that a generous public has built hospitals in the past and will continue to do so.

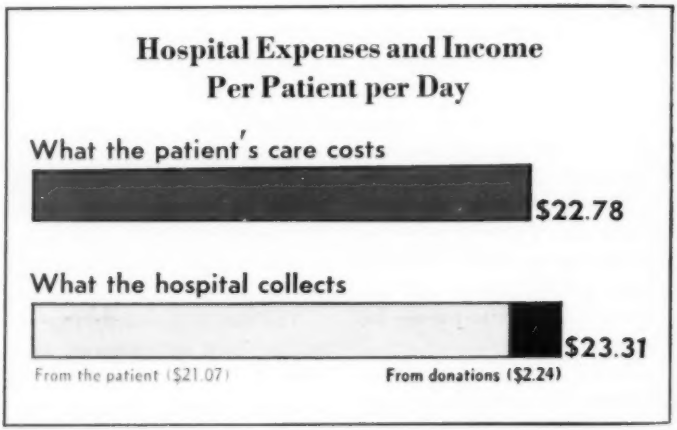
The fact is, however, that the public isn't so generous as it used to be. Nearly a third of current hospital building pro-

jects, including those getting Federal assistance under the Hill-Burton Act, are partly financed by mortgage loans. In these hospitals, amortization and interest payments must be made out of earnings. So patients pay higher rates.

The question about depreciation also comes up in connection with hospital rates paid by Blue Cross, insurance companies, and other "third party" payers of hospital bills. If depreciation is not included, the hospital is in effect subsidizing these agencies out of its contributed funds.

While hospital economists argue the depreciation question heatedly, the difference to the public is actually slight. More important are two other business sins that are still common in hospitals. These are:

1. Failure to provide adequate working capital—or any at all, in a number of hospitals. This results in a hand-to-mouth financial existence that often makes suppliers hold the bag for sixty to ninety days, or even longer, while the hospital juggles its receivables to shake out a little more cash. It's estimated that, in order to carry the average load of patients' accounts receivable, the hospital needs $1,000 of working capital per



patient. For a 100-bed hospital with 80 per cent occupancy, that means a working capital of $80,000. Few hospitals have anywhere near that much.

2. Below-cost rates for some ward accommodations. Many hospitals still accept less-than-cost payments for care of indigent patients who are public charges. This is being corrected, slowly but steadily. Hospital associations are gradually convincing public officials that below-cost payments amount to an unjust, involuntary tax on the sick. Patients who pay their bills (and hospital employes whose pay lags behind the rate for comparable jobs in industry) are carrying the difference.

Most doctors, and most of their patients, understand that nobody is making a fast buck out of the community hospital. The thing they wonder about is why hospital bills are so high. Many of them leap to the conclusion: "If there are no profits, there must be inefficiency."

This is the hospital's biggest public relations headache today. Unquestionably, there is some inefficiency in hospital management, just as there is in hotel management or any other human activity. In comparing hospital and hotel bills, however, as many people instinctively do, they overlook several costly and important factors:

¶ The hospital has 1.8 to 2 employes per bed; the average hotel has only 0.6 to 0.8 employes per guest.

¶ Forty per cent of hospital costs are consumed by around-the-clock nursing service, an item peculiar to the hospital.

¶ An additional 15 per cent of the hospital charge is for food and meal service, not included in the hotel's room charge.

¶ Professional services (X-ray and laboratory, operating and delivery room, and all others stemming from the hospital's medical functions) add another $7 to $9 a day on the hospital bill.

If all these hospital services were administered at maximum efficiency, a few cents a day might be squeezed out of the average $22.78 bill. Hospital administrators are aware of this. In recent years, their drive for management efficiency has brought about numerous changes. For instance:

There's increasing use of

practical nurses, nurses' aides, and ward attendants for nonprofessional nursing duties—e.g., taking and recording temperatures, carrying bedpans, arranging flowers, running errands, keeping clerical records on nursing floors. Practical nurses earn about 75 per cent of a graduate nurse's salary. Lesser trained personnel make substantially less, with resulting economies in nursing service.

They're Pinching Pennies

There's increasing reliance on efficiency studies. One result has been the general adoption of central tray service and other food-service economies requiring fewer people and less time to deliver meals to patients, with consequent savings.

There's increasing use of business machines. These have replaced manual record and accounting procedures in most hospitals—again with payroll savings and improved efficiency.

While hospitals are pinching pennies out of the operating budget, however, advancing medical technology keeps adding dollars to the hospital bill. For example:

Today's complicated anesthesia and radical surgery have made it necessary for the hospital to establish a post-operative recovery unit.

Routine use of blood and blood substitutes, parenteral fluids, and new medications have increased nursing responsibilities on the floors.

Introduction of new, high-voltage radiological equipment has increased the equipment obsolescence rate and added greatly to expenses in this department.

Radioisotope laboratories, unheard of five years ago, are an expensive necessity in the hospital today.

Spectacular advances in the realm of chemotherapy have enormously increased the hospital drug bill.

As these and many other medical improvements have added to the daily cost of hospital care, they have also cut down the length of hospital stays. The average stay in voluntary general hospitals last year was less than eight days, compared to the fourteen-day average of a few years ago. Thus today's average hospital bill of $175 is not much more than the aver-

age bill—at a lower cost per day, but for more days—of 1940.

Hospital administrators and trustees try to present these facts to patients and their families. They seek to combat wrong concepts about hospital bills and hospital inefficiency.

The Man Responsible

Without the doctor's help, however, this is uphill work. John Public looks to his family physician for the answers about his hospital care. If service is slow on the floor, or if his bill is too high, John turns to the man he holds responsible—his physician.

If the doctor shrugs and says, in effect, "Ain't it a shame?" the hospital may never have a chance to tell its financial story when anybody is listening.

In good times such as these, the hospital is full (average occupancy last year was over 80 per cent) and so is the cash register. But if hard times should come, the understanding of patients and their families could make a big difference. It could mean the difference between survival for our voluntary hospitals and the kind of financial trouble that might turn them toward accepting the last recourse: government subsidies.

To get full understanding, the hospital needs the help of its doctors. That's why hospital people are troubled about the doctor-hospital disputes that have arisen over such issues as credentials, staff privileges, and arrangements with specialists. In these disputes, both sides feel there are principles at stake which must not be sacrificed. One or two cases have been settled by negotiation, but others continue to flare up, in and out of court. It seems likely these differences may continue for years.

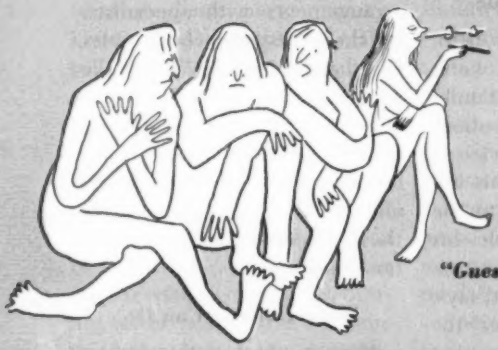
What Doctors Can Do

Here is a test of the doctor: Can he battle the hospital on a point of staff privilege and, at the same time, try to help out financially and win friends for the hospital among his patients?

If he can, the hospital as we know it will survive. If he can't, the whole system may be in trouble. For, as Dr. Albert Snoke, president-elect of the American Hospital Association, has said of the doctor-hospital disputes: "If we both don't win, we'll both lose." END

GYNECOLOGICAL GALLERY

These drawings aren't calendar art. They may not even be art. They just show what a gynecologist's examination room would look like—if nightmares came true



"Guess who's going to be next."

"I want you to stop calling me Doctor. My name is Harold."

"I don't know what it's called in Latin, but it's a hell of a nasty cramp."

"I'm awfully sorry, Mrs. Murphy I didn't realize my hands were that icy cold."

"Aren't you making a hell of a fuss over a wart?"

Selling a Practice in S

Here's a novel way for an older doctor to keep his income high until retirement, while helping a younger man get off to a fast financial start

• About ten years ago, a 55-year-old G.P., whom I'll call Dr. Jackson, asked me to help him map out a plan of action by which he could:

1. Reduce the long hours he was devoting to his practice;

2. Keep his earnings high despite the cutback; and

3. Be sure of selling the practice at a good price, if he should want to retire at 65.

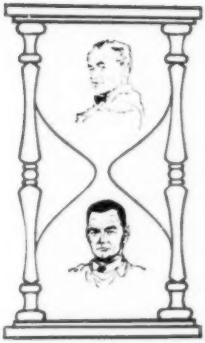
I advised him—as I have others—that he could probably solve all three problems by selling his practice "in slow motion." In other words, I explained, he could set up a partnership that would be designed, from the beginning, to terminate in a planned practice sale to his junior partner.

Dr. Jackson liked the idea, so he put it into action. Here's how:

THE AUTHOR *is president of Professional Business Management, a Washington, D.C., firm of tax and management consultants.*

ice in Slow Motion

By John C. Post



First he took on a prospective partner as a salaried assistant for one year. I helped draw up—and the two doctors signed—a special pre-partnership employment agreement. This specified that at the end of the year the doctors would, if mutually satisfied with the results of the trial period, form a legal partnership.

Fortunately, Dr. Jackson had found just the man he needed. His new associate, Dr. Babson, was 45. He'd had an earlier, successful practice disrupted by four years of military service. So he didn't relish the idea of building a new practice from the ground up. But the idea of working into a going practice suited him fine. Best of all, he was just at the threshold of his most productive years.

As you'll see from the pre-partnership employ-

ment agreement (page 111), Dr. Babson was to be paid $700 a month for the first year. Then, when the partnership was formed, he would get a percentage of net income that would increase each year for ten years, until equality was about to be reached. At that time, Dr. Babson would buy the full practice.

Exact details for the purchase were set forth in the partnership agreement, which eventually superseded the pre-partnership contract. Let's take a closer look at this document (parts of which are reproduced on page 112). There are two points especially worth noting:

1. *Division of income.* In the initial twelve months of the partnership, earnings were split on a 70-30 basis. Each year thereafter, Dr. Jackson's share has been cut two percentage points, while the younger man's has increased by the same amount. As you'll see from the table on this page, the actual dollars-and-cents division in that first year was $21,500 to $9,200. Last year, Dr. Jackson's share was $24,900, Dr. Babson's, $19,500.

2. *The practice-sale provisions.* At the end of 1957, the partnership will come to an end, when Dr. Jackson sells his share of the practice to his younger partner. For this, Dr. Babson will pay a sum equivalent to his partner's 1957 income. This is estimated at about $22,900.

Such a high figure for a practice sale may seem unrealistic. In many cases, it might be,

Partners' Annu

Year	Partnership Net Income
1948	$30,700
1949	32,200
1950	39,700
1951	44,200
1952	48,800
1953	45,100
1954	44,300
1955	44,400
1956	44,000
1957	44,000

*All figures have been

since there's often no guarantee that the retiring doctor's patients will continue with the other man. But the price Dr. Babson will probably pay seems fair enough under the circumstances:

For one thing, the two doctors will have been associated for over ten years; so there should be little falling-off in patient volume when Dr. Jackson retires. Then, too, the younger man actually got a larger share of the net income than he probably deserved during the partnership's early years. So Dr. Babson doesn't consider the sale price unjustifiably high.

There's a big tax advantage for both doctors under this arrangement. They're able to spread their earnings more evenly over the years. Thus

nnu hares of Total Income (1948-57)*

Dr. Jackson			Dr. Babson		
Age	Percentage	Share	Age	Percentage	Share
56	70%	$21,500	46	30%	$ 9,200
57	68	21,900	47	32	10,300
58	66	26,200	48	34	13,500
59	64	28,300	49	36	15,900
60	62	30,300	50	38	18,500
61	60	27,100	51	40	18,000
62	58	25,700	52	42	18,600
63	56	24,900	53	44	19,500
64	54	23,800	54	46	20,200
65	52	22,900	55	48	21,100

ed off to the nearest hundred. Amounts listed for 1956 and 1957 are estimates.

they avoid the big tax bite that makes peak-income periods a mixed blessing for many doctors.

Purchase Installments

Naturally, Dr. Babson won't pay the $22,900 in a lump sum, but in yearly installments. Exact annual amounts will be settled when the actual separation takes place. And here too the younger man will enjoy a tax advantage: The Treasury now considers such payments to a retiring partner as deductible business expenses for the remaining partner.

But suppose Dr. Jackson doesn't *want* to retire when he reaches 65? What then?

Retirement Alternative

We've anticipated this possibility in drawing up the partnership agreement. Section 11 specifies that Dr. Jackson must sell his partnership rights at the time agreed on. If he continues to practice in the same city, it must be in the same office, and on a rental basis. This will permit him to practice as little or as much as he pleases. But since he'd be paying 50 per cent of his gross income as a rental charge, there wouldn't be too much inducement to continue practice.

There's one other provision of special interest in the partnership agreement: It's the clause (Section 8) that concerns the financial settlement to be made in case one of the doctors dies during the life of the agreement.

In Case of Death

You'll notice that definite payment arrangements have been agreed on: The surviving partner would pay to the estate a fixed amount monthly for the two years following decease. But the exact amount of such payments has not been fixed in advance in the agreement.

Instead, the doctors hold an annual business meeting each February to decide how much each would pay if the other died during the next year. They feel that this annual evaluation makes it possible to establish a fairer settlement.

So far, I've discussed only the legal and financial aspects of selling a practice in slow motion. But there are other rewards. For example, Dr. Jackson derives immense satisfac-

Pre-Partnership Employment Agreement

THIS AGREEMENT is made this 10th day of December, 1946, by and between Harry Jackson, M.D., and Charles Babson, M.D.

Since Dr. Jackson is and has been for many years engaged in the practice of medicine and desires to employ Dr. Babson to assist him in his practice, and since Dr. Babson desires to accept this employment:

THEREFORE, in consideration of these circumstances, and the mutual benefits to be derived therefrom, the parties hereby contract and agree as follows:

1. Dr. Jackson does hereby employ Dr. Babson to assist him in his practice of medicine for a period of one year beginning the first day of January, 1947.

2. Dr. Babson agrees that all fees for his services, and all records pertaining thereto, shall be the property of Dr. Jackson.

3. Dr. Jackson agrees to pay Dr. Babson as compensation for his services, seven hundred dollars in each month.

4. Dr. Babson agrees that if he terminates employment and association with Dr. Jackson he shall not carry on the practice of medicine for at least two years within the area defined in a supplementary sketch which is a part of this agreement.

5. It is the intention of Dr. Jackson and Dr. Babson that, at the end of the term of this agreement, they will, if possible, mutually agree to form a partnership for the practice of medicine. The partnership agreement will specify that the percentage of net income to be paid to Dr. Babson will amount in the first year to at least as much as he receives under this employment agreement. His percentage shall increase progressively over the ten-year period of the partnership agreement, until equality in sharing is about to be reached.

IN WITNESS WHEREOF, the parties have hereunto signed their names and attached their seals.

Harry Jackson M.D.,
Charles Babson, M.D

CAUTION: *This agreement is for illustration only and not for use without legal advice.*

tion from knowing that the practice he built up will be perpetuated. Furthermore, he has been able to take regular vacations with no loss of income.

I realize, of course, that the "slow motion" concept isn't for every doctor. Your practice may be too limited for a two-man partnership. Or you may be the type who wouldn't want a colleague in your office. And, to be sure, it's never easy to find exactly the right partner.

Excerpts From the

THIS AGREEMENT is made this 15th day of December, 1947, by and between Harry Jackson, M.D., and Charles Babson, M.D. . . .

Section 6. In the first year (1948) the net income of the partnership shall be shared 70 per cent for Dr. Jackson and 30 per cent for Dr. Babson. Each year through 1957 Dr. Jackson's share will decrease 2 per cent and Dr. Babson's increase 2 per cent.

Section 7. At the conclusion of the calendar year 1957, Dr. Jackson shall separate himself from active participation in the medical practice of the partnership. In consideration of Dr. Jackson's release from his interest in the office furniture, equipment, fixtures, medical records and such of the intangible assets as cannot be evaluated readily, Dr. Babson agrees to pay to Dr. Jackson (or his estate) an amount equal to the net amount received by Dr. Jackson in the last year of partnership practice.

Section 8. Should death occur during the duration of this agreement, net income shall be divided according to the share then prevailing. Division of accounts receivable shall be made in the same percentage when and if liquidated. Also, the survivor, for the next twenty-four months following the month of decease, shall pay to the other's estate the amount decided on by the partners at their last annual business meeting. These meetings shall be held each year in the second week in February. It is understood that this payment is in lieu of an appraisal and payment for properties which cannot be evaluated readily.

But when the plan *can* be set up, it's often eminently successful. I had my latest indication of this when Dr. Babson dropped in to see me the other day.

With his present partner scheduled for retirement after next year, he's already talking about the need for a new man to help handle the practice. "I'll soon be old enough to start in on a slow motion sale of my own," he told me. END

Partnership Agreement

Section 9. Should permanent disability force the withdrawal of either partner, the remaining partner shall be bound to the same division of assets and to payments for the next two years as is provided in the case of death.

Section 10. In the event of dissolution for other causes than death or permanent disability, net profits and other tangible properties shall be divided according to the shares then prevailing.

Section 11. Should Dr. Jackson choose to continue the practice of medicine independently in this city after the year 1957, he may do so only in the office quarters of Dr. Babson or of any new partnership with which Dr. Babson is associated. Furthermore, he shall be allowed to do so only upon payment of 50 per cent of his resulting gross professional income, which shall be the charge for the use of the office and its facilities.

Section 12. If at any time during this agreement it should seem desirable by mutual consent that additional partners be acquired, they can be added, but the relative shares of Dr. Jackson and Dr. Babson, as set forth in Section 6 of this agreement, shall continue to prevail . . .

IN WITNESS WHEREOF, the parties have hereunto signed their names and attached their seals.

Harry Jackson M.D.,
Charles Babson, M.D.

CAUTION: *These excerpts are illustrative only and not for use without legal advice.*

American Doctor in Paris

By Nadeane Walker

• According to legend, American men who have lived right go to Paris when they die. One man who couldn't wait that long is Dr. Neil C. Rogers. He lives there right now.

Dr. Rogers, a trim, gray-haired surgeon from New Hampshire, is president of the medical board of the American Hospital of Paris. He's also an accomplished linguist, the father of a half-French daughter, and a veteran escort of visiting M.D.s bound for the Folies Bergeres.

The mixture suits him well. "I have all the advantages of a typical surgeon's practice in America," Dr. Rogers says happily, "and at the same time I live in the world's most cosmopolitan city."

Except for a four-year interval in the Army, Dr. Rogers has worked in the American Hospital since 1939. He's the only American doctor who's been

A DAY ON THE TOWN, when you live in Paris, can involve almost anything. Here Dr. Rogers gives his delighted daughter a ride down the steps of the Palais de Chaillot, as the Eiffel Tower looms up behind. Later he and 8-year-old Patricia may take a stroll along the Champs Elysees.

CHAMPAGNE AT NOON isn't a regular thing for Dr. Rogers (left). Here it's being drunk as a climax to the Parisian ceremony in which he was made an officer of the Legion of Honor. The man in the splendid uniform proposing the toast is Inspector General Rouvillois of the French Army.

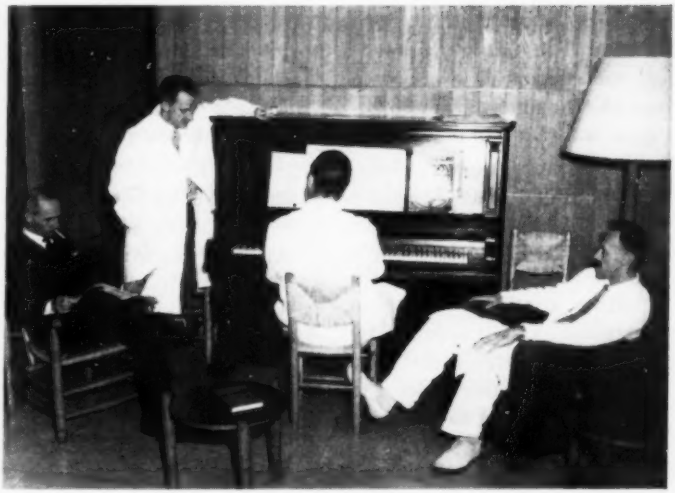
with the hospital since before the war.

Rogers took to France from the very beginning, and the affection seems to be mutual: The French Government has made him successively a *Chevalier* and an *Officier* of the Legion of Honor. Recently, too, he was elected secretary general of the all-medical *Institut Foch*.

Equally secure in French esteem is the American Hospital he helps run. From twenty-bed beginnings in 1910, it has grown to the point where it now has 153 beds.

Besides a long list of junketing U.S. Senators and movie stars, the hospital has housed such patients as the Aga Khan, the Duke of Windsor, and ex-

INTERNATIONAL ROUNDS are an everyday occurrence at the American Hospital. Here Dr. Rogers is consulting with Dr. Pierre Porcher of the University of Paris. It might just as easily have been an English, German, even a Portuguese M.D.



ALMOST LIKE HOME is the doctors' lounge at the American Hospital of Paris. Neil Rogers watches with a paternal eye as three of his internes (one from San Diego, Calif., one from Sussex, England, and one from Montreal, Canada) gather around the piano during a Sunday lull.

Premier Leon Blum of France. It also treats some 10,000 ordinary American visitors a year, mostly on an out-patient basis.

One reason for its popularity with tourists: It's the only hospital in Europe to hold membership in Blue Cross.

What's it like to deal so largely with transients? Wonderful, says Dr. Rogers:

"They say of the Cafe de la Paix that if you sit there long enough, you'll see everybody you ever knew go by. That's the way I feel about the American Hospital. The best-known medical men from all over come here to visit—and they're on vacation and ready to enjoy what I enjoy."

Other sources of pride to Neil Rogers are his hospital's accreditation by the Joint Commission (it's the only one off the North American continent to be so recognized) and its approval by the French Government as a "super-clinic." This entitles it to charge top rates of $8 a day for semi-private rooms, $11 for small singles, and $15-$20 for de luxe accommodations. "That's cheaper than most hospitals in the States," Dr. Rogers points out.

This American in Paris is equally enthusiastic about his private life. Though his marriage to a French girl ended in divorce, his romance with France is as fresh as ever. He still gets a thrill out of strolling by the Arc de Triomphe, and French cooking tastes just as good to him in 1956 as it did in 1939. But he's American enough "just to open a can" when he eats in his bachelor apartment in the smart Paris quarter of Passy.

On Rogers' days off from the hospital, he likes to wander past the bookstalls along the Seine, visit a cafe or two, and perhaps wind up attending a ballet at the Paris Opera. Even more, he enjoys exploring Paris with his 8-year-old daughter Patricia, who normally lives with her French mother.

It's been a big change for Neil Rogers from country boy to Paris surgeon. Sometimes he has trouble believing it, even now. But then he looks up at the Eiffel Tower. "We never had anything like that in New Hampshire," he says. And you get the idea that he wouldn't trade locations with any surgeon anywhere. END

How to Tame Your Telephone

By Wallace Croatman

Should you charge for phone consultations? Or set up a daily telephone hour? This study of what other doctors do will help you decide

• Maybe you've never stopped to figure it out. But chances are that you spend a full hour or more on the telephone every day.

Is it time well spent? If not, what can you do about it?

To get answers, MEDICAL ECONOMICS sent questionnaires to a national sampling of practicing physicians. In addition, personal interviews were conducted in various East Coast areas, from New York City to Atlanta, Ga. Here are the findings, based on the experiences of over 500 doctors:

From an economic standpoint, the basic telephone problem facing many an M.D. is whether he should charge for the advice he gives by phone. It's a problem that few have resolved affirmatively. Ninety per

Rude Awakenings

"Doctor, I've called every other doctor in town, and . . ."

● **There comes a time in every doctor's life when he decides it would be easier to live *without* his telephone. As N. C. Fuller of Rockland, Me., observes, that time is usually around midnight; and the caller uses one of these opening gambits:**

"Doc, thish ish Sharlie, an' I don' feel so good . . ."

cent of the surveyed men say they *never* charge a patient for such advice. Eight per cent *sometimes* do. Only 2 per cent *always* charge for telephone advice.

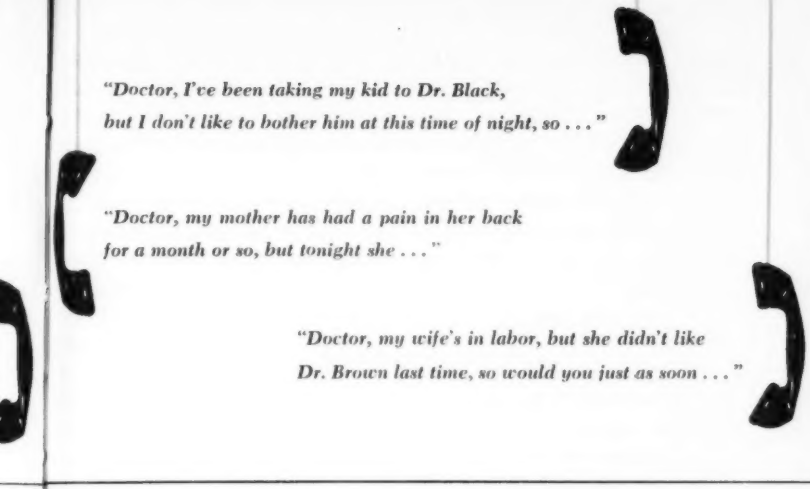
Among the 10 per cent who charge at least occasionally, the usual fee is $1. A few physicians report that they charge $2.

Several doctors tack on an extra charge if the call lasts longer than usual ($4 for a fifteen-minute call, according to one internist's schedule). And a California psychiatrist doubles his usual phone-consultation fee ($2) if the patient wakes him at night.

The doctors who charge sporadically take two factors into account: the patient who's calling and the kind of advice given. For example:

Bills Steady Callers

¶ A Greenville, Pa., physician says he bills only "the chronic offenders who rely on the phone for treatment and rarely come into the office." Thus, like many of his colleagues, he employs phone-consultation fees as a



means of discouraging such calls.

¶ A Trenton, N.J., doctor says: "I don't usually charge for telephone consultations. But I sometimes bill non-regular patients, especially if I think they're trying to get something for nothing."

¶ Says a Lake Charles, La., man: "I never charge for a call relative to a current illness that I'm treating. But I do bill other patients if I have to order a prescription as a result of their calls."

How do patients feel about paying for telephone consultations? They generally go along with the idea, say the doctors who charge. But there are some complaints.

"Those who gripe the loudest," says a Tacoma, Wash., orthopedic surgeon, "are invariably the ones who demand the most advice, require the most time, and take the longest to pay their bills."

Why They Don't Charge

Fear of patients' disapproval seems to be a big reason why the vast majority of surveyed doctors don't charge for tele-

phone advice. One young doctor sums up the general feeling this way:

"I think that by charging for phone calls I'd merely be antagonizing the patient. Once you start off giving such services free, it's pretty hard to change.

You Lose Patients

"An occasional doctor will want to cut down on his practice; he may then double his fees and lose half his patients. Well, I suppose the same thing can be accomplished by charging for telephone consultations.

"Of course, some patients will now consider the doctor twice as good and will be twice as anxious to get his services. But the average doctor isn't in a position to make such an experiment."

Then, too, some doctors feel that telephone charges involve more trouble than they're worth. As one medical man puts it: "I charged $1 a call for a short time during the war, hoping it would discourage unnecessary calls. But it didn't. Instead, my motives were misunderstood, and the extra bookkeeping was a nuisance."

Another frequent comment is that it's better to put up with a few foolish calls than to risk discouraging all calls from patients. Says a Florence, S.C., doctor: "If a patient is improving, I want to know it as much as he does." Several doctors also point out that they'd rather give free advice by phone than hop out of bed for a house call late at night.

Free telephone advice can also be a matter of pride. "I discontinued the charge," one M.D. explains, "because I decided the advice I gave was worth more than $1. Since I couldn't very well raise the fee, I decided I might as well give it free."

The Best Control

If you can't keep your telephone time from being a dead economic loss, there *are* ways of keeping it under control. The best way, according to the surveyed doctors, is to delegate as much telephone detail as possible to your aide. Roughly half of these men have their girls screen *all* incoming calls and put through only the urgent ones.

What sort of calls can the

aide handle on her own? Arranging appointments is, of course, the telephone duty most commonly delegated. Many doctors say they also expect their aides to handle all calls about bills and fees. Other frequently delegated telephone tasks: answering questions about insurance forms; arranging hospital reservations; answering routine questions about diets prescribed, injections given, etc.

50% Delegated

Says a Boston pediatrician: "If the parents would allow it, my secretary could handle 90 per cent of their calls. As it is, I wind up taking at least half of them. Too many people insist that they 'want to speak to the doctor'—even if it's only to set up an appointment."

Another pediatrician, who makes a good many follow-up calls, is assisted by his nurse in this way: She gets the parent on the phone, then turns the call over to the doctor. While he's talking, the nurse places a second call on another line. By the time the doctor has finished with the first, the second is ready for him. This routine enables the doctor to pack much of his phone-calling into half an hour toward the end of each day.

Another man, whose aide has been with him eight years, encourages her to spend enough time talking to each phone caller to take down all data on the complaint. She can generally boil a ten-minute conversation down to a tight description of what's wrong. After studying her notes, the doctor decides whether he wants to see the patient or whether he can handle the case simply by phoning back.

What about calls that the doctor must take himself? These usually interrupt office routine. But some physicians try to make them *part* of the routine:

Telephone Hours

They set up a definite telephone hour outside of regular office hours, and they ask patients to make all non-emergency calls during this period.

Pediatricians are most likely to maintain special telephone hours. One out of every three pediatricians surveyed says he does so. The idea also appears

to be relatively common among G.P.s and internists.

When a doctor has a telephone hour, it's apt to be early in the morning. From 8 to 9 is the most popular time.

Most such doctors say they take these calls at home, as a matter of convenience. But others get to the office an hour early for the telephone period. They use the time between calls for filling out insurance forms and other routine chores. As a rule, the doctor's aide is *not* present then.

How do you publicize a special telephone hour? Most of the doctors say they simply tell patients about it during regular office visits. But many of them also use printed notices on letterheads or calling cards, or even special announcements.

12 Calls an Hour

During a typical telephone hour, the doctor apparently takes a dozen-odd calls. Even so, he admits that he's likely to be called to the phone another twelve to fifteen times daily.

Yet doctors with telephone hours seem enthusiastic about the idea. Some typical comments:

¶ From a Philadelphia Ob./Gyn. man: "It definitely makes for fewer interruptions when I'm treating patients."

¶ From a Michigan orthopedist: "It enables me to follow patients' progress more closely on matters not requiring an office visit."

His Wife Answers

¶ From a Tennessee G.P.: "The telephone hour helps me set up the daily schedule of office and house calls. Thus I avoid many an interruption later on. And the morning phone hour is relatively painless to me, because my wife handles most of the routine calls."

On the other side, about 10 per cent of the surveyed men say they've tried a telephone hour and then decided against it. Their reasons:

Some found that the special hour didn't cut the volume of phone calls at other times. Others found that the hour was *too* popular. Either the doctor couldn't keep up with the ringing of three or four phones, or his patients protested repeated busy signals.

Finally, a number of M.D.s

became convinced that the telephone hour invites patients to call over trivial matters they'd otherwise shrug off.

Which leads to the $64,000 question: How do you get your patients to make only necessary calls?

No doctor claims to have an answer to that one. Still, most of the respondents maintain that their patients are reasonably considerate. "The average call," says one man, "usually has *some* medical basis. And if it hasn't—well, I'd rather be bothered by an unimportant query than risk failing to hear about a serious condition."

Why They Phone

Apart from calls for appointments, here are the main reasons why patients phone the doctor:

(1) They need a new prescription or a renewal; (2) they want to describe various minor symptoms; (3) they want to report progress or lack of progress; (4) they'd like information about lab tests, X-rays, and such. Ranking right up with these telephone topics (especially for pediatricians and G.P.s) are questions about formulas, feeding, and behavior of children.

One physician jotted down some of the questions asked by his patients in a recent three-month period. He doesn't claim they're typical questions, mind you. But a few of them may sound familiar to you:

The Things They Ask!

"Our whole family has the flu. Will you have the druggist send us something, so we don't have to go to your office?"

"Dr. Black said so and so. Do you think that's possible?"

"Baby swallowed soap while bathing. What should I do?"

"When can I sneak in to see you without having to wait?"

"Do you think my dentist's bill is too high for the work he did?"

"It's windy out. Should Junior wear a sweater under his coat? Or should he stay in?"

"How long should you cook pork to have it well done?"

"Can my son catch measles from another boy four blocks away? They don't play together."

Some doctors have proved to their own satisfaction that people *can* be educated into using

the phone more wisely (i.e., more sparingly). One such man is Bernard P. Harpole, a Portland, Ore., G.P. who sends out a mimeographed newsletter with his monthly statements. Not long ago, Dr. Harpole began one of these letters this way:

"On my day off last week I had to visit several people in their offices . . . Each visit was interrupted by one to three telephone calls. I'm sure that I spent much more time on each visit, waiting for them to finish with the phone than I did talking with them . . .

"This experience convinced me . . . that it's much better [for the doctor] to call back than to allow a phone call to interrupt consultations. Many of you know that it's a little difficult to reach me immediately by telephone during office hours. You also know that you don't have to spend most of an afternoon in my waiting room. I've found that it's one or the other . . .

"Speaking of wasted time, I'll bet I spent at least two hours in all waiting for people to find pencils during the recent 'flu' epidemic. When you call, please have a pencil and a note pad by the phone, so you can write down instructions. It will also help if you have the phone number of your druggist written down . . ."

They Need Educating

Dr. Harpole says this letter got results. And if you don't feel like writing long letters to your patients, you can still drop verbal hints to the same effect. The taming of your telephone probably depends on this. END

Howler

When a woman lists her symptoms,
That's the time to spike all rumor.
For if you fail to run a test,
You may later spank a tumor.

—PAT WINSELL

Tax Relief for Your Retirement Savings?

By James Daniel

Here's how the best-informed observers view the 1956 chances of Jenkins-Keogh-type legislation

• During the past few years, you've been hearing a lot about the possibility of a Federal tax deferment to aid the self-employed in building up their retirement savings. This year, once again, Congress has a chance to bring the "possibility" to life.

Is it likely to do so?

An informal survey of Washington policy-makers reveals a good deal of cautious optimism on the subject. There's real steam, in both Administration and Congressional circles, behind the idea that self-employed doctors and others are now treated unfairly taxwise when they put aside money for their old age.

But there's disagreement as to how this unfairness can be removed. Some legislators, for instance, insist on compulsory Social Security coverage as a first requisite. "Come under Social Security and base your retirement planning on that," they say. "In return, we'll grant you tax relief on *additional* retirement savings." [MORE▶

None the less, it's widely accepted that present Federal income tax laws do discriminate against the self-employed. Here's how this came about:

During World War II, while corporations were paying up to 90 per cent income taxes, Congress granted extraordinarily favorable tax treatment to company pension plans. Corporate income put into such plans was made tax-exempt. It became subject to income taxes only when actually received by beneficiaries—and then at the much lower rates retired persons pay.

▶ **It is difficult for me to state categorically what the chances are for enacting the Jenkins-Keogh bill this Congress. I propose, however, to utilize every parliamentary maneuver to accomplish this objective . . . It certainly seems to me that any tax deferment on retirement savings would be of practical help to [self-employed physicians and others].—*Eugene J. Keogh, member of Congress representing the Ninth District, New York.***

A recent study by the Treasury showed that some $2.1 billion of corporate income was going into retirement plans annually. Another $1.8 billion was going into health and welfare plans. Total: almost $4 billion annually of currently untaxed corporate earnings.

Some authorities think the correct figure may be closer to $5 billion today. That much money, if taxed at usual rates, would bring Uncle Sam about $2.5 billion—more than enough to balance the Federal budget.

Considering this tax-exempt treatment of company pension plans, it's no wonder that the self-employed doctor feels left out. If he wants to set aside funds for his old age, he can. But he has to do it *after* paying his income taxes—not *before*.

The groups that have long urged a better deal for the self-employed include the American Bar Association, the American Dental Association, the American Farm Bureau Federation, and of course the A.M.A. Their efforts brought some progress last summer: The House Ways and Means Committee held hearings on the bill sponsored by Representatives Thomas A.

Jenkins (R., Ohio) and Eugene J. Keogh (D., N.Y.). The committee also considered a substitute bill introduced by Representative John H. Ray (R., N.Y.).

High point of the hearings was the admission by Treasury Secretary George Humphrey that present tax laws *are* unfair to the self-employed. No Secretary of the Treasury had ever been willing to say that in public before.

But the Secretary didn't go much further. As guardian of the U.S. Treasury, he probably couldn't.

To show why, let's run briskly through the pending proposals as they now look, halfway through the House Ways and Means Committee:

The Jenkins-Keogh bill would allow you to put 10 per cent of your earned net income, up to an annual maximum of $5,000, into a privately managed retirement fund. (The bill had originally allowed $7,500 a year; but the committee lowered the ceiling.)

During your lifetime you could set aside a sum as high as $100,000 in this way. (Again the committee cut the figure.

▶ Although I am a sponsor of [Jenkins-Keogh-type] legislation, I am not optimistic about enactment at this session of Congress. The revenue loss would be substantial. Any change in tax legislation which brings with it revenue loss must compete with other such changes on the basis of . . . which corrects the greatest inequity.

The merits of Jenkins-Keogh-type legislation which would put . . . professional persons on a par with corporate employes are great . . . We cannot continue [the existing tax inequity] much longer without serious undesired economic effects. None the less, the matter is chronic rather than acute.

Personally, I am more anxious to see some support for my proposed (and rejected) amendment to the Social Security law. This would permit any person who desires to provide his own retirement program equivalent to . . . Social Security . . . to be excused from the Social Security tax.—*Thomas B. Curtis, member of Congress representing the Second District, Missouri.*

which had originally been $150,000.) And you would pay no current income taxes on such sums.

If you were over 55 when the bill went into effect, you could set aside an *additional* 1 per cent of net earnings for each year that your age exceeded 55. If you were 57, for instance, you could put 12 per cent of your annual income into your retirement fund; if you were 60, 15 per cent; and so on.

> ▶ **We could support a proposal to give all taxpayers a break *after* the inequity is removed through passage of the Jenkins-Keogh bill. Any general lowering of taxes which does not include . . . enactment of the Jenkins-Keogh bill will not restore equity . . . Frankly, our chances this session are better than fifty-fifty.—*Frank G. Dickinson, director, Bureau of Medical Economic Research, American Medical Association.***

At age 65, then—or earlier, if you suffered total and permanent disability—you could begin withdrawing your money. If you took it out in a lump sum, it would be taxed as a capital gain. If you took it out in annual, quarterly, or monthly sums, you would pay regular income tax rates. And, naturally, you'd be saving tax money, since you'd then be in a lower bracket.

The Ray bill scales down your allowable savings. It would permit you to set aside only 5 per cent of your net income annually. And the first year the bill was in effect, you could put no more than $1,000 into your retirement fund.

The second year, the ceiling would rise to $2,000. It would go to $3,000 for all succeeding years. Thus, presumably, the revenue loss to the Treasury would be postponed somewhat.

The Ray bill doesn't specify a lifetime limit. But, like the Jenkins-Keogh bill, it would permit additional set-asides if you were past your earning peak when the law went into effect. You could add 1 per cent for each year you were past the age of 50.

Under the Ray bill, you wouldn't be allowed to pay the low capital gains tax if you

drew your retirement money out in one lump sum. Instead, you'd divide the money into five equal parts and pay five times the regular income tax due on one-fifth. (That means you'd pay less than the full regular tax, but more than the long-term capital gains tax.)

For obvious reasons, the Treasury Department likes neither of the above bills. Secretary Humphrey is probably as sympathetic as anybody to the problems of the self-employed. But his first job is to fill the Government's coffers. After all, the Administration hasn't yet made good on its pledge to balance the budget and cut taxes generally.

So you can't expect much direct help from the Secretary. When reminded that the 1952 Republican platform endorsed the objectives of the Jenkins-Keogh bill, he said:

"It is not only these 10 or 11 million self-employed people, but the whole 50 million [employed] people who are in my opinion paying taxes that are too high. There are a great many discriminations, and we are trying to remove them as rapidly as we can . . ."

The Treasury figures that the Jenkins-Keogh bill would cost $275 million a year in lost revenue if limited to the self-employed. If it were extended also to employed persons who don't have pensions, Treasury men say the tax loss would have to be estimated at at least $1 billion annually.

▶ Any tax relief that Congress may enact this year will benefit people with lower incomes than self-employed professionals. With a budget to be balanced, the Jenkins-Keogh bill holds a very low priority, in my judgment . . . In any event, I doubt that Congress will grant tax relief of this type to professions outside the Social Security system.—*Gerald G. Gross, editor, Washington Report on the Medical Sciences.*

And the Department fears political complications if either of the proposed bills were to go into effect. For example, what about pensionless *employed* persons?

The Treasury feels that they

▶ I doubt if the Jenkins-Keogh bill will pass this year, because the Treasury will be unwilling to forgo current tax receipts from professional persons . . . The Government's philosophy under Social Security has been to collect taxes promptly and to defer benefits. I doubt that the Government will now be willing to defer *taxes* . . .

Further, I doubt that tax deferment on restricted retirement savings would help the self-employed in a practical way . . . Few persons, except the very wealthy, would be willing to make an irrevocable decision to set aside retirement savings in an annuity contract that impounded the savings until the prospective annuitant reached age 65, died, or became permanently and totally disabled . . .

What is needed is not one more patch on the income-tax fabric, but a thoroughgoing overhaul of the Internal Revenue Code. The Jenkins-Keogh bill is a palliative, not a cure. —*Marjorie Shearon, editor, the Shearon Medical Legislative Service.*

shouldn't be given similar tax relief, since they can always negotiate with their employers for company pensions. But such a stand lays the Department open to attacks from labor spokesmen, who can accuse the Treasury of favoring a "rich man's bill."

The House Ways and Means Committee has actually voted to limit Jenkins-Keogh help to the self-employed. But when Congress gets busy on 1956 tax changes, liberal legislators will probably try to extend the benefits to everybody. One idea that's already being talked about: a tax break on retirement savings to *all* taxpayers, even to employed persons who already have company pensions.

Meanwhile, only one thing's sure: The Eisenhower Administration hasn't much time left, if it wants to make good on one of its '52 campaign promises before the next election.

George Roberts, chairman of an American Bar Association committee on retirement benefits, pleads the case as follows: "We are not asking this for . . . the love of any Park Avenue doctors or corporation lawyers.

It is [because of] the feeling that this bill is for the benefit of the young and the middle-aged of all professions . . ."

An even more eloquent spokesman, Dwight D. Eisenhower, said in October, 1952:

"When [pension-fund] legislation was being considered, self-employed individuals were evidently forgotten. *Yet they grow old and sick just as other people do.* There are over 10 million workers who cannot take advantage of these tax-free provisions now offered to corporations and their employes. They include owners of small businesses, doctors, lawyers, architects, accountants, farmers, artists, singers, writers, independent people of every kind and description . . .

"I think something ought to be done to help these people help themselves, by allowing a reasonable tax reduction for money put aside by them for their own savings.

"This would encourage and assist them to provide for their own funds for their old age and retirement. If I am elected, I will favor legislation along these lines."

This is the last year in which the present Administration can redeem that pledge. END

Toilet Training

● A colleague of mine was making a house call on a cardiac patient. Since the house was overflowing with the sick man's relatives, he found that the bathroom was the only place he could talk privately with the nurse on duty.

They shut the bathroom door behind them, and the doctor sat down on the closed toilet seat and proceeded to give his instructions.

When he'd finished, the doctor stood up and the nurse opened the door. Then—as a whole roomful of cousins watched—the doctor reached back from sheer force of habit and flushed the toilet. —J. MORGAN KELLUM, M.D.

The Doctor's Tastes { Highbrow? Lowbrow? Middlebrow?

[THE PRIVATE LIFE of the U.S. physician—his health, his family, his personal habits, his politics, his social activities, his community service, his recreation—is now being examined by MEDICAL ECONOMICS in a series of nation-wide polls. Upwards of 1,200 questions, divided into categories, are being asked of samples of male physicians in private practice. Each physician is given only one category of questions, but a total of 15,000 doctors will be queried in all. This is the fifth article based on their replies.—ED.]

• What are the doctor's tastes in music, art, the theatre, literature, the movies, television, and such? How much time does he give to such diversions? MEDICAL ECONOMICS' latest survey indicates the answers. And they point to one broad conclusion:

The U.S. physician can't be typed. His range of interests is wide. His tastes are exceedingly catholic.

Let's examine the specific results of the survey. Where, to begin with, does the doctor go in search of sedentary amusement?

Where He Finds Entertainment

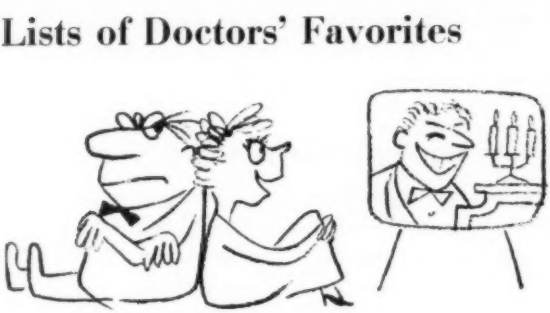
Like most Americans, the typical respondent goes to the movies much more often than to the theatre. He attends more musical comedies than operas. And he hardly ever goes to the ballet or to art exhibits.

Mostly, he entertains himself at home. He reads nonclinical literature for an average of four hours a week. Or he watches television (three nights a week). Or he listens to the radio.

The typical doctor of those surveyed went to five movies during the last twelve months. Only 5 per cent of the men didn't go at all. About the same percentage went once a week or oftener.

Three out of five have seen at least one play during the past year; and about half of the playgoers attended the theatre three or more times. (One ad-

Lists of Doctors' Favorites



You can tell a lot about the doctor's tastes from the adjoining lists. Among actresses, for example, he goes more for refined elegance (Grace Kelly) than for raw sex (Marilyn Monroe). Yet there's something redblooded about his preferences in general. His favorite television programs (live sports events) include prizefights, football games, and baseball games, in that order of preference. Pretty clearly, he cannot be classified as either a highbrow *or* a lowbrow.

Favorite Columnists

1. Drew Pearson
2. Westbrook Pegler
3. Walter Winchell
4. Robert Ruark
5. The Alsops

Favorite Magazines

1. Life
2. Time
3. Reader's Digest
4. Saturday Evening Post
5. Newsweek

Favorite Recent Books

1. The Caine Mutiny
2. Not as a Stranger
3. The Egyptian
4. The Citadel
5. Something of Value

Favorite Movies

1. Mr. Roberts
2. The Caine Mutiny
3. Not as a Stranger
4. The Seven Year Itch
5. Cinerama

Favorite Authors

1. Ernest Hemingway
2. Erle Stanley Gardner
3. William Shakespeare
4. Somerset Maugham
5. Herman Wouk

Favorite Plays

1. South Pacific
2. Mr. Roberts
3. The Teahouse of the August Moon
4. Guys and Dolls
5. Oklahoma!

Favorite Actors

1. James Stewart
2. Clark Gable
3. Alec Guinness
4. Gary Cooper
5. Cary Grant

Favorite TV Programs

1. Live sports events
2. Ed Sullivan Show
3. Groucho Marx
4. Jackie Gleason
5. George Gobel

Favorite Actresses

1. Grace Kelly
2. Bette Davis
3. Helen Hayes
4. Marilyn Monroe
5. June Allyson

Pet Hates on TV

1. Arthur Godfrey
2. Milton Berle
3. Soap operas
4. I Love Lucy
5. Give-away shows

dict—a New Yorker—tells of having seen *thirty* stage performances in the twelve-month period.)

Only one doctor in three found his way to an art gallery during the year. An Eastern internist says he "saw too damn many during five recent weeks in Europe."

And even fewer of the respondents attended the opera. One reason: 62 per cent say they actively dislike it.

Only 22 per cent of the men polled attended ballet or dance recitals during the year. But 47 per cent went to at least one concert. (One man says he attended twenty-two.)

His Reading Habits

The typical respondent spends thirty minutes a day with his favorite newspaper. Half the time, it's a paper published fifty miles or more from home.

He reads the news and editorial columns, then turns to the sports and comics pages. Next, he'll read the columnists and the obituaries. (Only one doctor in 450 admits he reads a newspaper medical column.)

What else does the doctor read for diversion? He seems to like fiction and nonfiction equally well. About a third of the novels he reads are thrillers; 15 per cent are science fiction; and 8 per cent are novels about doctors.

He prefers history and biography to science. But some 20 per cent of the biographies he reads concern physicians.

He Knows What He Likes

In pictorial art, the doctor's taste appears to be conservative. All but 27 per cent of the men who expressed an opinion say they can't stand the modern stuff.

In music, more than half the surveyed doctors prefer the classical and symphonic to any other type. Nineteen per cent favor semiclassical; 15 per cent, "popular"; only 6 per cent are enthusiastic about full-fledged jazz.

One of the respondents' pet hates is the way in which doctors are portrayed on stage, screen, and TV. Here are some typical comments from practicing physicians on this point:

¶ "Doctors are seldom shown as they really are. They're either too heroic or too neurotic."

¶ "They have a way of coming up with the answer too fast and too surely."

¶ "They're too sour-faced, serious, and generally overpoweringly dull."

¶ "The surgeon," complains an internist from Oklahoma, "is glamorous enough already. On the screen his glamour is increased a thousandfold. As a result, the rest of the profession suffers—at least when it comes to fees!"

Still, a sizable minority (26 per cent) feel that the doctor is being played fairly realistically these days. And many of

the respondents give some credit for this to the television show "Medic." A typical comment: "I believe 'Medic' has been of help to the whole medical profession."

But "Medic" is by no means the doctor's favorite television show.* For real relaxation, the average physician apparently prefers to tune in on a prize-fight or ball game.

On the whole, the typical respondent isn't crazy about television (though 86 per cent of the men own sets). Two-thirds of the doctors say they like it—but only for selected programs. The rest are pretty acid about it. Some typical comments from medical men:

¶ "I feel it's producing a race of morons. But much as I hate it, I still watch."

¶ "It's terrible; but like cigarettes it gets to be an addiction."

¶ "Apparently I like it too well to suit my wife, who wants to be talked to."

*For the respondents' favorite shows—as well as their best-liked books, movies, actors, magazines, etc.—see the lists on pages 136-137, where choices are listed in order of preference.

Hillbilly Logic

● A mountaineer I had treated for twelve days in the hospital—and who had paid nothing—was making a post-operative visit to my office. He asked my aide if he could use the phone, and promptly made a call to a taxi service in a town some twenty-five miles away.

"Pick me up at Doc Nailling's office in Asheville," he said. "I want fer you to drive me home."

The call cost 60 cents; and the mountaineer handed the receptionist a dollar bill.

"Miss, you keep the change," he said. "I'm sorry I don't have no money to pay the doctor with. But you tell him I sure will give him a good name."

—RICHARD C. NAILLING, M.D.

You've Got Some Wrong Ideas About Your Patients

And they've got plenty about you and your profession, this brand-new A.M.A. study indicates. Here are its most surprising economic highlights

● The facts on the following pages stem from "What Americans Think of the Medical Profession," the A.M.A.'s important new public relations study released this month.

Ben Gaffin & Associates, the Chicago research firm that made the study, has produced 200-odd pages of conclusions and cross tabulations. They're based on interviews with 3,000 persons representing the public and 500 physicians in private practice. Estimated cost of the exceptionally thorough job: $125,000.

Many of the findings echo those of earlier studies. Much of the report concerns the public relations of organized medicine and the doctor's opinions of medical officialdom. Medicine and its mentors will be busy interpreting the results for months to come.

Meanwhile, MEDICAL ECONOMICS brings you the most striking *new* findings, as they affect the individual physician in his own practice:

Most physicians (71%) believe people resent their fees. But few patients (13%) volunteer this criticism.

Even when asked specifically about it, less than half the patients say that doctors charge too much. People are more likely to mention that doctors "don't take enough time," are "cold, impersonal," or "won't come when called."

Most people (76%) think physicians should give advance estimates of their fees. Most doctors (77%) say they do, or are willing to. But less than half the patients (48%) confirm this claim.

Frankness about fees is apparently less widespread than either doctors or patients would like. The statistics suggest that it's up to physicians to take the initiative here. More candor about medical matters is also indicated. Nearly half the patients and nearly half the doctors agree that most medical men "are not frank enough in talking to patients about their illnesses."

Most physicians (62%) favor the sliding scale over fixed fees, while patients are about evenly divided.

The question asked was: ". . . Should [doctors] charge more to patients who have more money?"

Surprisingly, high-income people vote more strongly for the sliding scale than low-income people do.

Very few people (3%) think G.P.s are likely to overcharge. Less than one-third (29%) believe surgeons are likely to overcharge. About half (54%) think "other specialists" are likely to overcharge.

"Other specialists" seem to be whipping boys here. Apparently the people who criticize doctors' fees don't want their criticism to reflect on their own family doctor or their own surgeon.

Nearly one-third of the people (31%) believe most doctors charge higher fees to people who carry health insurance. More than a scattering of doctors (18%) agree.

Only one-eighth of the people believe that their own doctors are guilty of this. So, where their personal physicians are concerned, patients seem less critical than doctors are. This phenomenon recurs throughout the survey.

Most physicians (81%) think the problem of fee splitting has been exaggerated to the public. But they favor stern measures to stamp it out.

[MORE ▶

The stern measures against fee splitting favored by the medical profession include medical society expulsion and revocation of licenses. Milder measures are mentioned almost as often, however—especially the establishment of an "equitable fee scale" for medical procedures.

Most people (62%) don't know what fee splitting is. And those who do know don't necessarily condemn it.

The well-informed minority was asked: "What do you think should be done about fee splitting?" Of those with firm opinions, only about half said "Stop it" or "Take action against it" or "Legislate against it." The other half said things like "It's all right," "Leave it to the doctors," "Tell the patient about it."

Most people (62%) like the idea of grievance committees. Physicians favor the idea by an even wider margin (81%).

The question asked: "Do you think that there should or should not be local doctors' committees to which dissatisfied patients can take their grievances?" The answers suggest that doctors are more keenly aware of the need for professional self-discipline than patients are. Among the doctors' stated reasons for supporting such committees: "to handle overcharges" . . . "to control malpractice" . . . "protection for public."

Most people (67%) think their doctors are good businessmen. Most doctors (81% think they're not.

Patients base their conclusion on the fact that their doctor "lives well, has a big car, a large home." Besides, they don't think anyone that "intelligent and capable" can be a poor businessman. But the doctors say they're "too busy," too short on "business training," to be good businessmen.

A majority of patients (51%) believe that existing health insurance meets their needs. A majority of physicians (53%) believe it doesn't.

The divergence here is greater than the percentages indicate, since many in both groups are uncertain. Among patients with firm opinions, the satisfaction ratio is 5 to 3. Among doctors with firm opinions, the *dis*satisfaction ratio is 5 to 3.

A majority of people (53%) think there's a shortage of doctors. A majority of doctors (58%) disagree.

Among the physicians, in fact, one out of five thinks there's an oversupply. Almost nobody—doctor or patient—believes the profession is trying to hold down the number of physicians.

[MORE ▶

Besides providing the new findings reported on the preceding pages, Ben Gaffin & Associates have substantiated a number of old hunches and long-established axioms.

Their report reminds the doctor that patients object to long waits; that they want him to come quickly when he's needed; that they want personal, unhurried attention. The report further indicates:

A majority of people (54 per cent) think that doctors try to cover up each other's mistakes. Almost one-third of the people believe that most doctors get rebates from druggists.

Plenty of people think that most doctors are too quick to recommend operations, too prone to double-talk their patients, "have the idea they're always right."

Even so, just about everybody who has a family doctor thinks he's wonderful—and different from all the rest! END

Skin Game

● Like other dermatologists, I use the lengthy titles given to skin diseases. But I'd never seen much advantage in the system—until the day I examined a patient with a truly bizarre eruption.

"Well, Doctor," he asked finally, "what have I got?"

I had no idea. Taking refuge in jocularity, I answered: "It's a rather rare skin disease called Dermatitis Confusiformis."

The patient gave a sigh of relief. "Thank God," he said. "Four doctors I've been to, and you're the first who knows what's wrong with me!"

—CARL E. LIPSCHULTZ, M.D.

Do YOU Have an Economic Blind Spot?

By Greer Williams

Many doctors do, this analyst says, because of muddled thinking about medical ethics. He urges a realistic view of the profit motive in medicine

• The A.M.A. is trying to make more sense out of the Principles of Medical Ethics. Ever since 1952, the little booklet that you are advised to live by has been up for revision.

It still is.

At the A.M.A.'s December meeting, the Council on Constitution and Bylaws proposed to divide the present code into two sections: medical ethics and professional etiquette. The House of Delegates tabled the proposal until next June, so that every member of the A.M.A. would have time to think about it. The House, as a matter of fact, asked that a copy of the proposed code be sent to you, as an individual member, so you could have a voice in the matter.

Important piecemeal changes have been made in

EDITOR'S NOTE: Your motives in practicing medicine may not always coincide with the Principles of Medical Ethics. And when they don't coincide, the fault may not be yours. As the late Dr. H. Sheridan Baketel, editor-in-chief of MEDICAL ECONOMICS, wrote three years ago:

"In explaining medical ethics to the public, the A.M.A. often relies on the descriptive phrase, 'The Code Your Doctor Lives By.' Yet the average doctor *doesn't* live by the code—at least not to the letter. He can't. Too many passages are vague, contradictory, or years behind medical practice . . ."

Ethics experts haven't solved this problem. Indeed, they shouldn't be expected to solve it on their own. "Our code needs . . . revamping . . . not just by ethics experts," Dr. Baketel concluded, "but also by specialists in semantics."

Men with a gift for articulate analysis are numerous within the

the Principles during the last three years. Some of the old familiar sins relating to unfair competition and restriction of individual freedom have been erased. After some realistic appraisals, sharp disagreements, and a few complete turnabouts, the House has:

¶ Made it easier for doctors with something worth saying to court Osler's Delilah—the press—without having their ethical locks shorn.

¶ Relaxed the separate billing rule enough to let independent practitioners render combined itemized bills and to divide the fee in surgical insurance cases.

¶ Spared such men as Alvarez

profession. But they haven't yet expressed themselves in sufficient numbers. To encourage them to do so, MEDICAL ECONOMICS has turned to one of the "specialists in semantics" outside the profession. The accompanying article—the first of several on medical ethics—is a result.

Greer Williams, the author, is a longtime profiler of doctors for The Saturday Evening Post. He has some stimulating, even shocking, things to say about the profession's motives. You may not agree with all he says.

But this article and the ones to follow do not purport to be the last word on medical ethics. They are, rather, the first realistic attempt to answer some unspoken questions in almost every doctor's mind. One of these, herewith: "How can I balance public service with the profit motive in my daily practice?"

The last word on questions like this is up to *you*.

and Spock the odium of being classed as unethical because of their health columns and baby books.

¶O.K.'d doctor-dispensing of drugs, eyeglasses, and so on, provided the patient doesn't get clipped.

¶ Made it possible for a doctor-inventor to market a medical patent at a fair profit without being automatically classed as a pirate.

Do these changes mean that medicine is headed toward complete commercialization? (I have close doctor-friends who view the liberalizing of medical ethics with a horror usually reserved for the crimes of incest

and rape. They fear that the selfless physician whom the world loves and honors is about to be sacrificed on the altar of materialism.)

Or do the changes mean simply that private medicine is about to become as realistic and as candid as private business is? In other words, do they mean that the modern doctor—like the Ford Motor Company and the Bell Telephone Company—is ready to admit that he has a profit motive as well as an obligation to provide a good product and good service?

Your Own Viewpoint

How you react to what the A.M.A. is doing to your code may depend on how you've learned to look at such questions.

Quite a few physicians, in my observation, have an economic blind spot. They don't recognize their own profit motive. They don't like to talk fees with patients. They don't like to admit that they derive financial gain from serving sick humanity.

The intelligent layman sees through this blind spot. He's aware that private physicians *must* profit if they are to serve humanity properly. He knows perfectly well that they *should* talk fees. He knows that they get a big economic as well as spiritual lift from their profession.

'Father Figures'

But why, he asks, are they so skittish about it?

Ernest Dichter, psychologist and recent surveyor of medicine's motivations, may have the answer. He sees physicians as firm but kindly father figures, with patients as dependent children. In an emotional relationship of that kind, discussions of price are admittedly distasteful.

This, I suspect, is why the doctor so often avoids all talk of fees until his service has been rendered.

But it isn't his intention to *forget* the fee. He simply dissociates it from the job at hand.

The patient doesn't. He gets the economic connection the minute the doctor's bill comes in.

The private practitioner is in the incongruous position of having dedicated himself to humanity and to the profit motive

at the same time. This being the case, some guilt feeling is probably inescapable.

Yet the bogy is mostly in the doctor's own mind. People realize his situation and accept it –with more understanding than he suspects.

A recent survey shows that Americans *don't* resent the doctor's making money. Our whole standard of living is built on individual opportunity for profit. It's practically un-American to be against financial success.

What people *do* resent are implications that the profit motive doesn't exist in medicine. Their intelligence is insulted when a doctor keeps pointing with one hand to the selflessness of medicine while raking in fees with the other.

Here, from the speech of a doctor-friend of mine before a Rotary Club, is a sample of

"I was married at Echo Lake. Could *that* explain it?"

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what makes for poor listening:

"Food, clothing, and shelter vie with medical care in almost equal importance to health. But no obligation is assumed by the producers and purveyors of these commodities to recognize poverty in fixing prices, or as a reason for gratuitous service."

This practitioner's income from patients undoubtedly puts him in the upper 1 per cent of the nation's wage-earners. Yet he didn't hesitate to take a bow on behalf of himself and his colleagues for the free medical service they give. Nor did he hesitate to low-rate a group of merchants, some of whom had no doubt carried financially embarrassed customers on the cuff at some risk of going broke themselves.

You're Not Alone

Actually, American business sometimes goes American medicine one better—and without claiming any special moral virtue. Take the Great Atlantic & Pacific Tea Company. The other day, while waiting in a supermarket check-out line, I fell to reading the "A. & P. Pol-

icy," up there on the wall over the bookkeeper's cubicle.

It was short and to the point. It began by advising employes: "Do what is honest, fair, sincere, and in the best interests of the customer." It ended with this: "Cheerfully refund customer's money if for any reason purchase is not satisfactory."

This huge corporation, frankly in business for profit, had found it worth-while to emphasize the customer's interests ahead of its own. It even found it desirable to offer a money-back guarantee of satisfaction.

Sliding Scale

That's more than doctors can do, of course. It's unscientific and unethical to guarantee a cure. They can, however, do something the grocer can't: They can justify raising their fees to the well-to-do to make

"Sometimes I wonder about the progress of medicine—ten minutes to give a patient medication and an hour to fill out his medical insurance forms."

up for service to patients who pay little or nothing.

But what special moral virtue, the hard-headed businessman might ask, is there in offsetting losses with gains—or in using charity as a loss leader?

Hint From Hess

Moral pretentiousness in the face of the economic realities has too long been a liability in medicine's campaign for public goodwill. "It's possible," says A.M.A. President Elmer Hess, as if summing up the argument, "that we spend too much time telling each other what great humanitarians we are . . ."

During the late "public confession" of surgery's ethical sins, Dr. I. S. Ravdin was one of several to decry the public billing of physicians as a "superior" group. "Doctors," he remarked to me, "are but a good cross-section of our American citizenry. They really aren't any better or any worse than anyone else."

Those Young Doctors

You often hear the older men of medicine deplore signs of commercialism in younger doctors. Not long ago, one medical leader publicly scolded the "postwar generation" for falling into "twin pitfalls of avarice

NOW— for truly effective cough therapy
— a choice of **2** forms:

ROBITUSSIN®

"The effective cough medicine of choice"[2] with documented[1,2] superiority. In each 5 cc. teaspoonful:

Glyceryl guaiacolate 100 mg.
—most powerful of all expectorants, increases RTF almost 200%.

Desoxyephedrine HCl 1 mg.
—relieves bronchial spasm while improving the mood of the cough-weary patient.

—in a highly palatable syrup vehicle

ROBITUSSIN® A-C

(Robitussin with Antihistamine and Codeine)

For comprehensive treatment of coughs aggravated by an allergic factor or a hypersensitive cough reflex. Provides the expectorant-antitussive and sympathomimetic action of Robitussin, plus...

Prophenpyridamine maleate 7.5 mg.
—a potent antihistamine, noted for its freedom from side effects.

Codeine phosphate 10 mg.
—the first choice of cough suppressants, highly effective, yet non-addictive.

EXEMPT NARCOTIC

NEW

REFERENCES:
1. Blanchard, K. and Ford, R. A., Effective Antitussive Agent in the Treatment of Cough in Childhood, Journal-Lancet, 74:443, Nov., 1954.* 2. Cass, L. J. and Frederik, W., Comparative Clinical Effectiveness of Cough Medication, Amer. Pract. and Dig. of Treat., Vol. 2, p. 844, October, 1951.*

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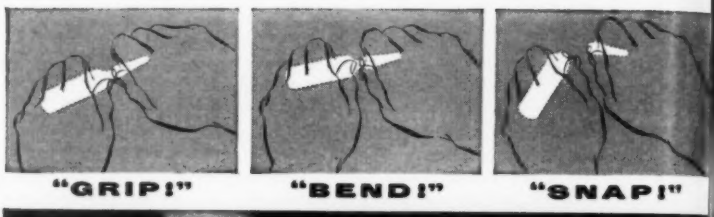

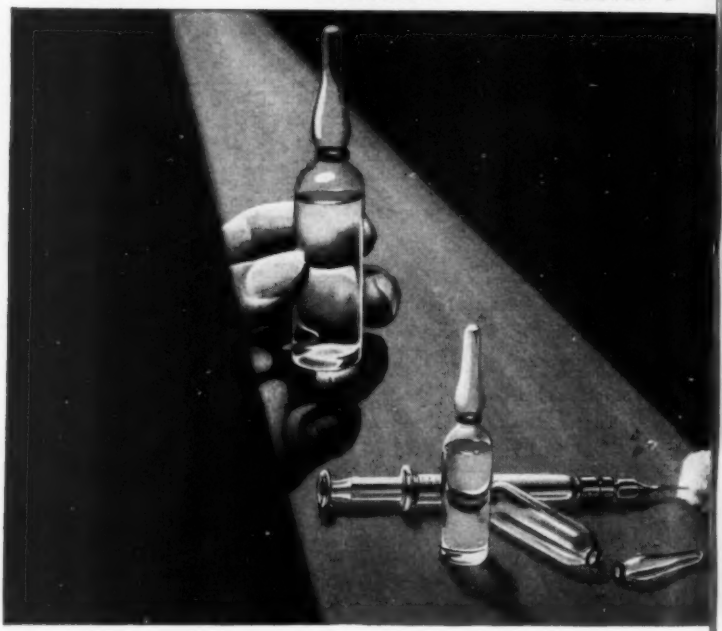

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and ill-gotten gains. They persuade themselves that they are justified in what they are doing."

So they do. And so did their elders.

Think of some of the great names in clinical medicine. Weren't most of these men big financial successes in their practices? Of course they were.

Take, for example, Dr. J. B. Murphy, who introduced prompt surgery in the treatment of acute appendicitis and became a co-founder of the American College of Surgeons. In one year before World War I, he earned a quarter of a million dollars.

The man who makes a good doctor usually makes good money too. There is no way of divorcing the fee-for-service principle from the profit motive. All we need is recognition of the fact that, in doing good for others, the good doctor justifiably does well for himself.

If those responsible for revision of the Principles of Medical Ethics can accept this sort of straight thinking, they'll spare the doctor a lot of professional and public confusion about his motives. END

The Paper Treatment

● Pat, fresh over from Ireland, came to my doctor-husband for treatment of a leg wound. After my husband had cleaned and dressed the wound, he wrote out a prescription for salve. "Put this on every day with a clean bandage," he said to Pat, "and come back in three days."

In three days Pat was back.

"How's the leg?" the doctor asked.

"Sure, and it's fine," said Pat. "That spell you gave me did the trick."

And he was right. For when my husband removed the bandage, there was the prescription slip itself—placed directly on top of the healed wound.

—HELEN RAYMOND O'CONNOR

This Estate Plan Dovetails Investments, Insurance

By Arthur Wiesenberger

Here's a suggested program for the young physician who wants protection for his family and a comfortable retirement income for himself

• This is the story of how one young doctor draws up a simple estate plan to provide protection for himself and his family.

Dr. Albright, as I'll call him, is 40 years old, married, and with three children ranging from 2 to 6 years in age. He owns a home-office, and he has what he feels is a sufficient cash reserve—about $5,000—to cover emergencies. He also carries $50,000 worth of straight life insurance; and he has plenty of disability insurance. But he owns neither Government bonds nor any other securities.

The doctor now figures that, after meeting his living expenses, taxes, and insurance payments, he can save about $300 a month. So he bases his estate planning on that amount. By using it intelligently, he wants to get:

MR. WIESENBERGER *is senior partner of Arthur Wiesenberger & Company, publishers of "Investment Companies," a standard work on mutual funds.*

1. Protection for unforeseen emergencies, such as protracted illness of one of the family.

2. Provision for the family if he should die before the children are self-supporting.

3. Adequate retirement income for himself and his wife if he chooses to retire in twenty years, at age 60.

Tools He Uses

As a private physician, he can not yet plan on getting either Social Security benefits or any kind of pension. So the two main tools he has to use in estate planning are life insurance and investments (chiefly in common stocks). Each has advantages and drawbacks:

Pros and Cons

For example, insurance enjoys more favorable tax treatment; but it offers no hedge against future inflation. On the other hand, stock investments generally provide some hedge against a decline in the value of the dollar; but they don't guarantee (as insurance does) a fixed dollar return.

The best solution for him, Dr.

no spill
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•
WHEATON SCORE-BREAK AMPULES
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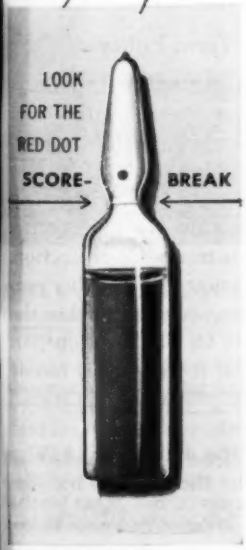
•



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Because the Score-Break Ampule is so easy to open, the contents are less likely to spill. And the score makes a clean break certain.

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Albright decides, is to set up a program combining insurance and investments so as to balance some of the risks of each. Here's how he does it:

The Early Years

First, he reasons that if he should die within a few years, the income from his present $50,000 life insurance policy wouldn't give his family enough to live on, to say nothing of college educations for the youngsters. So while the children are young—and until he can build up a fairly substantial investment account—he believes his first requirement is additional life insurance.

Term Policy

Since this need is temporary, the doctor decides on a *term* policy. For $50 a month, or $600 a year, he buys a $60,000 ten-year renewable policy that will more than double his family's immediate insurance protection. He can renew it at a higher premium rate when he reaches the age of 50. Or he can drop part (or all) of it then if his family no longer needs the additional protection.

With the remaining $250 a month, he then builds his "living estate":

Tetrazets.

BACITRACIN-TYROTHRICIN-NEOMYCIN-BENZOCAINE TROCHES

in sore-throat weather—a 4-in-1 attack

MAJOR ADVANTAGES: Provide three potent antibiotics plus a soothing topical anesthetic. Effective against both gram-positive and gram-negative bacteria. Little danger of sensitization.

Winds and showers bring sore and inflamed throats; new TETRAZETS provide the ideal topical treatment.

TETRAZETS are soothing, pleasant-tasting troches, each containing bacitracin, tyrothricin and neomycin, with benzocaine, added for its anesthetic effect.

The 3 antibiotics together (1) enhance the antibacterial potency, (2) extend the antibacterial range, and (3) minimize development of secondary invaders.

Prescribe TETRAZETS before and after tonsillectomies, too. They are valuable also as an adjunct to parenteral antibiotic therapy of deep-seated infections such as Vincent's infection.

Supplied: Vials of 12 troches, each troche containing 50 units zinc bacitracin, 1 *mg.* tyrothricin, 5 *mg.* neomycin sulfate with 5 *mg.* benzocaine.

SHARP & DOHME

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He determines to put $75 a month into U.S. Savings Bonds and $175 into three mutual funds of the common-stock type. (In his investment account he emphasizes stocks over bonds because his insurance program already represents a substantial purchase of "fixed dollars.") He also decides to reinvest all his mutual fund dividends in additional shares.

For the sake of flexibility in future handling of his capital, the doctor earmarks no specific sums for his children's education. Reason: By the time they are ready for college, his income may be big enough to take care of their expenses. If not, he can then either discontinue his investment program for a while or cash in some of his Government bonds.

Alternate Insurance Plan Offers Less

• If Dr. Albright had decided to base his estate planning entirely on insurance, what sort of program could he have set up with the $300 a month he had available? In answer to that question, one insurance adviser drew up a plan using a number of specific policies to cover various needs as they might arise.

Dr. Albright felt that this plan offered far less than the insurance-plus-investments program that he eventually chose. Here's how he viewed the pros and cons:

The all-insurance program offered him somewhat more retirement income at age 60 (about $425 a month) than the investment plan (about $360 a month). But in order to pay $425 a month, the insurance plan envisioned using up accumulated capital. So the doctor would be able to leave little, if any, estate to his children.

Furthermore, if the doctor's wife outlived him, the all-

How large will his retirement fund be after twenty years, when he's 60? And how much income will it produce? Assuming that the doctor keeps his program going without interruption, that he pays all his taxes from current earnings, and that savings bond terms remain unchanged, here's what he'll have in 1976:

¶ $50,000 of permanent life insurance, with a cash surrender value of about $25,000. If he wants, he can convert this into an annuity when he retires at 60. This will provide him with a monthly income of $125 for life; and it will continue to pay his wife $85 a month if she outlives him.

¶ Slightly over $28,000 in maturity value of U.S. Savings Bonds, or about $24,000 in im-

---

insurance plan would pay her a relatively small annuity ($115 a month) after she reached 65. Under the investment plan, on the other hand, she'd have both an annuity ($85 a month) and the income (say, $200 a month) from a stock investment of at least $67,000. Then, too, at her death, she could leave the principal of her estate to her children.

Before rejecting the all-insurance program, Dr. Albright asked himself this question: Would it provide more protection than the investment plan while his family was growing up? He found that it *would* provide a few thousand dollars more *if* his death occurred within the next couple of years. But if he died after that, the chances were that the total value of the insurance-investment program would increasingly exceed the proceeds payable under the all-insurance plan.

So the doctor decided that on both scores—retirement income and family protection—the insurance program offered him less.

in patients with colds... sinusitis... rhinitis

unplug *that* *stuffed-up nose*

orally *with*

Novahistine®

The marked synergistic action of a vasoconstrictor with an antihistaminic drug provides marked nasal decongestion and promotes normal sinus drainage. Oral dosage avoids harmful misuse of topical agents... eliminates nose drop rebound. Novahistine causes no jitters or cerebral stimulation.

3 dosage forms
elixir
tablets
fortis capsules

Each Novahistine Tablet or teaspoonful of Elixir, provides 5.0 mg. of phenylephrine HCl and 12.5 mg. prophenpyridamine maleate. Novahistine *Fortis* Capsules contain twice the amount of phenylephrine for those who need greater vasoconstriction.

PITMAN-MOORE COMPANY *Division of Allied Laboratories, Inc.*, Indianapolis 6, Indiana

mediate redemption value. These will mature, over the following ten years, at the rate of $234.68 a month.

¶ A good-sized investment in common-stock mutual funds. Into this account he will have paid directly a total of $42,000. And, based on past experience, he will probably have added to it more than $25,000 of dividend income. His estimated total investment will thus be more than $67,000. (The actual *market* value of the stock in future years, naturally, can't even be guessed at.)

But suppose Dr. Albright doesn't live to complete his investment program. How will his family be situated if he dies after the plan has been operating for, say, five years? In that case his wife will have the assets shown in the table below.

Mrs. Albright can thus expect a fair-sized sum with which to provide for herself and three children aged 7 to 11. Here's one way for her to use it:

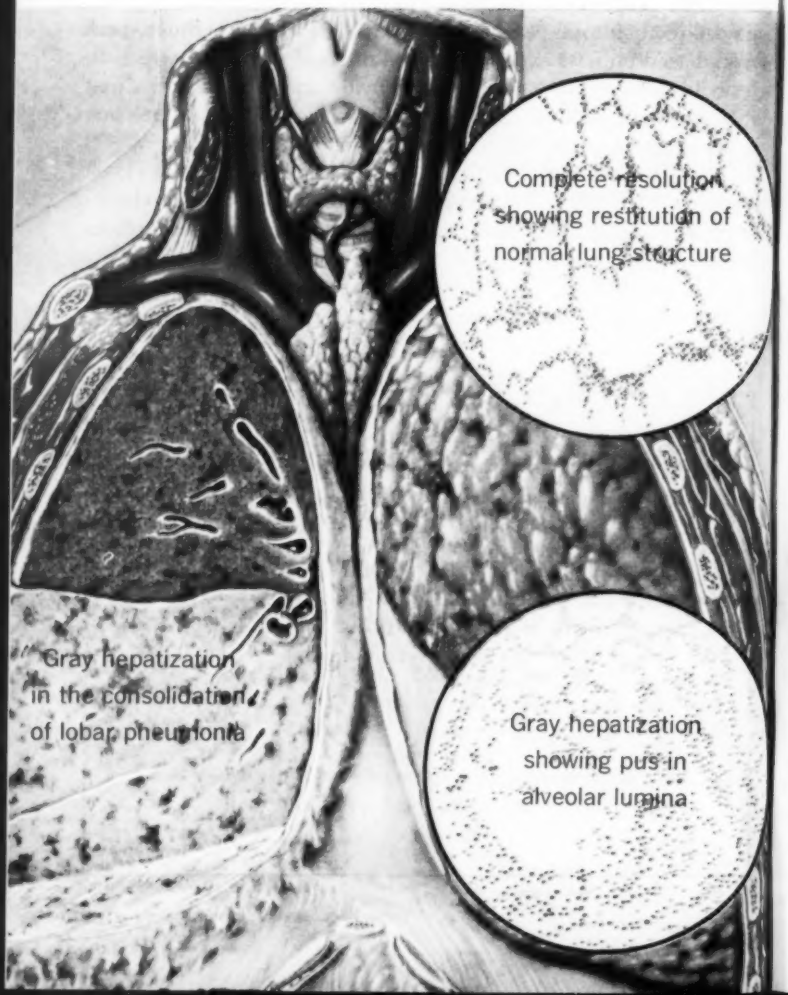
She can divide the $5,000 cash reserve between a checking and a savings account, in order to take care of current expenses and possible emergencies. [MORE▶

Estate After Premature Death

Insurance proceeds (straight life)	$ 50,000
Insurance proceeds (term)	60,000
Savings bonds (cost $4,500) with redemption value of	4,730
Mutual fund shares (cost, $10,500, plus some $1,400 of reinvested dividends)	11,900*
Cash reserve	5,000
	$131,630

*Market value may, of course, be either more or less than the total amount invested.

Most useful antibiotic for the most prevalent infections



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(ERYTHROMYCIN, LILLY)

Over 90% of all bacterial infections of the chest are caused by organisms highly sensitive to 'Ilotycin.'

Fully as effective against pneumococci as any other antibiotic.

In pneumococcus pneumonia, fever and acute symptoms subside within forty-eight hours. The pneumococcus-killing action of 'Ilotycin' is especially valuable in elderly patients and in debilitated states.

More effective against streptococci than the tetracyclines.

'Ilotycin' is bactericidal. The great majority of originally positive throat cultures become negative within twenty-four hours. Thus the possibility of complications is minimized.

The most effective antibiotic against staphylococci.

More than 90% of all staphylococci encountered in private practice are highly sensitive to 'Ilotycin'—more than to any other antibiotic.

Safe and well tolerated.

Staphylococcus enteritis and avitaminosis have not been encountered.

Dosage in pneumonia: 1.5 to 2 Gm. orally per day, in divided doses. Continue for a minimum of fourteen days. Children, 5 mg. per pound of body weight q. 6 h.

Tablets, pediatric suspensions, drops, I.M. and I.V. ampoules.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

ESTATE PLAN

She can hold onto the savings bonds and mutual fund shares until the oldest child is ready for college and then begin converting the shares gradually into cash. (Meanwhile, she would, of course, continue to reinvest in the fund all dividends received from it.)

She can arrange to take the proceeds from the $50,000 straight life insurance policy in the form of family income—a guaranteed $235 a month—for fifteen years.

At the end of fifteen years, she can take the rest of the money in a lump sum of $23,500; or she can buy an annuity with that amount to pay her about $100 a month for life.

Income for Her

Finally, she can use the proceeds from the $60,000 term policy to establish an investment fund. This will provide additional family income. It can also be Mrs. Albright's principal support after the children are independent.

What sort of investment fund will she establish? Well, in her case it may be advisable to put about half the $60,000 into a "balanced" mutual fund (one that features both stocks and bonds) and the other half into

the first names in hematology
call 'Feosol' the last word in

IRON THERAPY

Such well-known hematologists as Castle, Dameshek, Minot, Moore, Stevenson, Strauss, Wintrobe—to name a very few of very many—have recognized ferrous sulfate as the preferred form of iron.

'Feosol', of course, is a superior presentation of ferrous sulfate. Because of its special coating, it is easily tolerated. Because it contains exsiccated ferrous sulfate, it is, grain for grain, the most effective form of iron. 'Feosol', therefore, will produce a rise in hemoglobin which often averages 1% per day.

'Feosol', furthermore, costs your patient only a few cents a day. Yet, each tablet contains 3 grains exsiccated ferrous sulfate—the equivalent of approximately 5 grains (0.3 Gm.) of crystalline ferrous sulfate.

Smith, Kline & French Laboratories, Philadelphia

FEOSOL* *the standard iron therapy*

*T.M. Reg. U.S. Pat. Off.

a diversified common stock fund. This will allow to some extent for both relative stability and possible appreciation of capital. The yield from such an investment should—on the basis of recent figures—be about $175 a month.

What She'll Have

Thus, her total income for the next fifteen years after the doctor's death will probably come to around $410 a month. (Naturally, the income from the mutual funds won't be guaranteed, as will the insurance payments. On the other hand, there may be appreciation in the capital value of the funds, which there can never be in the value of the insurance.)

Children Benefit

Dr. Albright obviously hopes that his wife will never have to worry about such matters. He hopes he'll be alive at 60 and free either to retire under the plan or to spend several more years in active practice. In the latter event, the plan he's chosen will provide a substantial estate for his children. END

Conservative Therapy For Anorectal Distress

RECTAL MEDICONE

relieves painful anal lesions — ulcers abrasions — thrombosed hemorrhoids

In serious rectal involvement—where severe pain and discomfort are the patient's chief complaint[1] – the insertion of Rectal Medicone affords dramatic relief, thus enabling the clinician to proceed with therapeutic measures for treatment of the basic condition.

millions prescribed yearly...

[1]*Bargen, J. A., and Jackman, R. J., Journal Lancet, 72:11, Nov., 1952.*

MEDICONE COMPANY • 225 VARICK STREET • NEW YORK 14, N.Y.

Erythromycin in treatment of abscess

6/21/55

DISCHARGE SUMMARY

On 5/23/55 this patient (colored female, age 24) underwent an excisional biopsy of a breast tumor. On 5/24 tumor was removed and patient discharged from hospital on following day.

On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

Communication to Abbott Laboratories.

specific against coccic infections

Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that provides *specific therapy* against staph-, strep- or pneumococci. Since these organisms cause most bacterial respiratory infections (and since they are the very organisms most sensitive to ERYTHROCIN) doesn't it make good sense to prescribe ERYTHROCIN when the infection is coccic?

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(Erythromycin, Abbott)

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with little risk of serious side effects

Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to alter intestinal flora—with an accompanying low incidence of side effects. Also, your patients seldom get the allergic reactions sometimes seen with penicillin. Or loss of accessory vitamins during ERYTHROCIN therapy. *Filmtab* ERYTHROCIN (100 and 250 mg.), bottles of 25 and 100. Abbott

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STEARATE

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60H08

How the Credit Boom Is Hurting Physicians

By Rollen Waterson

The present installment-buying spree makes people less able to pay doctor bills—and more dissatisfied with partial-coverage health insurance

• Consumer credit has never been higher than it is right now. U.S. wage-earners were $35 billion in debt at the last count—and this figure didn't even include mortgages. While such overextension of credit is deplorable, in my opinion, it's an established fact. So we'd better learn to live with it.

Have wage-earners adjusted to this credit economy? Have business firms? Have doctors?

My answers must be recorded as two "Yeses" and one "No."

Consider the typical wage-earner today. He's learned to budget his income almost to the last dollar *before* it's even received. Amounts are reserved for food, clothing, utilities, recreation, and incidentals. The balance goes into installment payments on the home, the automobile, the furniture, and the latest appliances. [MORE ▶

THE AUTHOR *heads Rollen Waterson Associates, a San Francisco firm of public relations consultants.*

Predictable future expenses, too, are handled by the budget method. There are Christmas clubs, educational funds, retirement and burial plans.

'Dollar Down' Plans

In addition, there's insurance against *un*predictable future expenses. It's bought on the "easy payment" plan, and it's expected to protect the family economy against loss of savings.

Modern business makes every effort to fit sales and collections to this credit economy. In a current national magazine, Ford advertises: "Pay as you GO." U.S. Steel urges the purchase of a new home for low monthly payments. Oneida advertises a silver dinner service on "convenient budget terms." A Magnavox TV "can be yours for only $1.54 a week." For $4 a week, Mutual Life will give your family $10,000 if you die. You can even take a lengthy ocean voyage to those faraway places "with low budget payments after you return."

What about doctors? If they buck the prevailing economic pattern, their collections almost

inevitably suffer. But, fortunately, they don't have to buck it. Here's why:

They have a mechanism—health insurance—that's just right for budget-minded families. At least it should be just right. Here is a consumer credit-creating mechanism into which people are willing and eager to pay in advance. They are willing and eager because they understand health insurance to be a way they can put unpredictable medical expenses on a budget basis.

Too often, however, they find that health insurance *doesn't* protect them against unpredictable medical expenses. And that's when the current credit boom hurts private physicians most.

No Ready Cash

In many families today, there are almost no liquid assets. When they pay a big doctor bill, they have to drop something in their budget—perhaps a washing machine, an automobile, or an insurance policy. The money they've spent in installment payments is lost, too. The result is frustration and anger at what they feel is the failure of their health insurance.

True, many other families do have liquid assets. Their cash reserves fluctuate around a median of about $350. So they're able to pay a doctor's bill over and above the insurance. But how do they feel about it?

They Feel Cheated

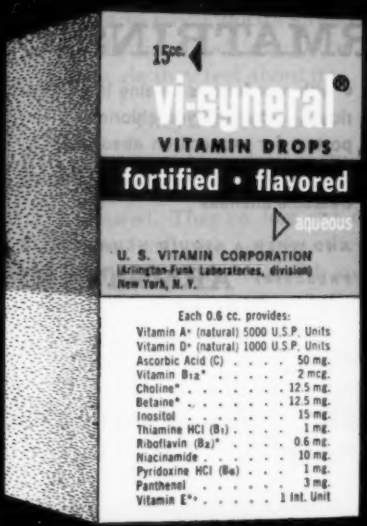
In our public relations studies, we have found that they feel cheated. They've lost not only their hard-won savings; they've lost their faith in health insurance.

What can doctors do about it? They can push their health insurance plans toward paying a

now...
a great
new
aqueous
multiple
vitamin
drop
formula

DELICIOUS

Vi-Syneral Vitamin Drops Fortified has a delightfully pleasing lemon-raspberry taste



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new... provides:

growth-promoting vitamin B_{12}

lipotropic choline, betaine, inositol, to aid carbohydrate and fat metabolism

pyridoxine (B_6), anti-convulsant vitamin ... other essential B-complex factors

vitamin E for muscle tone

100% natural vitamins A and D —water soluble, better absorbed and utilized

no burp, no fish oil taste or odor—allergens removed

vi-syneral vitamin drops fortified (flavored)

AMPLES to the profession on request—

U. S. vitamin corporation

rlington-Funk Laboratories, division)

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XUM

bigger part of big doctor bills. For these are the bills that hurt most in a credit economy.

The first thing doctors need to do in this connection is to help their plans establish realistic fee schedules. The second thing they need to do is to accept the scheduled fees as full payment in the usual case. They may also need to make the usual-fee plan community-wide. Without this sort of cooperation, health insurance can never protect its subscribers from expensive surprises.

Budgeted up to the eyeballs, with future earnings already consigned to creditors, the typical wage-earner today is in no mood for expensive surprises. He expects physician-sponsored health insurance to spare him these.

No Other Choice

If it doesn't, he'll soon be shopping for another kind of health insurance. And he won't care particularly if it's closed-panel or government-sponsored. Not if it brings his medical expenses almost wholly within his budget. END

DOCTOR, FOR YOUR ELDERLY PATIENTS, TOO, **INSTANT RALSTON'S** ADDED WHEAT GERM IS EXTRA NUTRITIOUS.

Why I Bought Bank-Loan Life Insurance

David E. Sullivan, M.D.

By borrowing money for premiums, this doctor was able to get a lot of protection at relatively little cost. His plan may possibly work for you

• Some time ago, I was faced with a dilemma that's familiar to many doctors. With a wife and children who were used to living comfortably—if not luxuriously—I felt I needed more life insurance than I could afford.

I could have bought an inexpensive term policy, of course. But I decided against term insurance for several reasons I need not go into here.

I talked the problem over with my insurance adviser, and he suggested a plan that I'd like to pass on to you. At reasonably low cost, he explained, I could buy a non-term life insurance policy that would give my family maximum protection for as long as I wanted it.

"I call it bank-loan insurance," he said. "And it's just what the name implies: You borrow money from a bank to pay your premiums. Your only out-of-pocket expense is interest on the loan. That way,

you can get much more insurance coverage than would be possible with pay-as-you-go insurance."

"Let's hear more about it," I asked. "How does it work?"

"First," he answered, "you decide on the amount and type of insurance you want. Since the policy itself becomes collateral for your bank loan, it obviously has to have cash-surrender value. So you'll have to buy either limited-payment or ordinary life. I'd suggest ten-payment life insurance for you.

You Borrow Money

"When you buy your policy, you also set up a loan agreement with a bank. As each annual premium comes due, you borrow the money to pay it. And the bank gets a first lien on the policy as security.

"At the end of each year, you pay *only the interest* on your debt—probably about 3½ per cent of the growing principal. It won't be much at first: about $260, say, for your first premium loan on a $100,000 ten-pay policy. Each year thereafter, your interest payments will get bigger. But so, of course, will the cash value of the policy."

"It sounds expensive," I interrupted.

[MORE▶

IN DIABETES...

greater security against vascular complications

Increased threat of vascular complications in diabetic patients can result from recurring episodes of inadequate control; at such times amino acids are "wasted" by de-amination in the liver and normal dietary security against lipotropic deficiency fades.

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"Less so than you think," said my adviser. "For there's an income-tax-saving feature, too. Your interest payments are deductible. And since you're in the 50 per cent tax bracket, your real cost should come to only about half the amount you have to pay the bank.

Your Assets Grow

"Meanwhile," he went on, "your policy accumulates cash value and (if it's a participating policy) dividends. If you cash it in after paying the final premium, it will yield more than enough to melt your snowballing debt. If, on the other hand, you keep the policy in force after it's paid up, you'll simply go on paying the same amount of annual interest to the bank.

"When you die, the bank takes your total loan out of the policy's face value (plus accumulated dividends). Whatever's left goes to your beneficiary. So you never have 100 per cent protection. It shrinks from 92 to 25 per cent of the policy's face value as your debt to the bank grows.

"But when you stop borrow-

ing from the bank, your net insurance protection climbs as more dividends accumulate. Anyway, you *need* less protection as your income rises and your children grow up."

The idea seemed good to me. But the insurance adviser warned me to give it plenty of thought before taking the plunge. "There are advantages, but there are also risks," he pointed out.

Among the advantages of bank-loan insurance, as he summed them up for me, are these:

¶ *Security for the young doctor's family.* Bank-loan insurance permits the young man to buy much more coverage than he could ordinarily afford—and to buy it at an age when premium rates are still moderate.

Lowest First Cost

¶ *Adequate protection at lowest initial cost.* For the first few years, the insured actually pays less than he would for term insurance. Yet he gets all the benefits of non-term coverage (except, of course, that death benefits of a bank-loan policy are always less than its face value).

¶ *The tax-saving feature.* This can become even more attractive in later years, because the biggest interest payments are likely to come during peak earning years. And tax savings on in-

Bank-Loan Insurance

Cost vs. Benefits*

When you reach age:	Your annual cost (interest on loan less income tax deduction) will be:	And after repaying loan, your survivor would receive:
40	$ 148	$93,535
41	296	87,172
42	444	80,913
43	592	74,759
44	740	68,716
45	888	62,784
46	1,036	56,973
47	1,184	51,243
48	1,332	45,621
49	1,480	40,236
50	1,480	41,435
51	1,480	42,668
52	1,480	43,946
53	1,480	45,271
54	1,480	46,734
59	1,480	54,595
64	1,480	64,014

*This example is based on a ten-payment life insurance policy with a face value of $100,000. Premiums of $7,421 a year are paid with money borrowed at 3½ per cent interest. The insured has an annual taxable income of about $25,000. This enables him, on a joint return, to deduct 43 per cent of his interest payments. Dividends are allowed to accumulate, and are included in benefits.

terest payments are highest, of course, in the highest income brackets.

What's more, any future rise in your Federal income tax rates will mean even greater savings on your bank-loan insurance.

Why They Want It

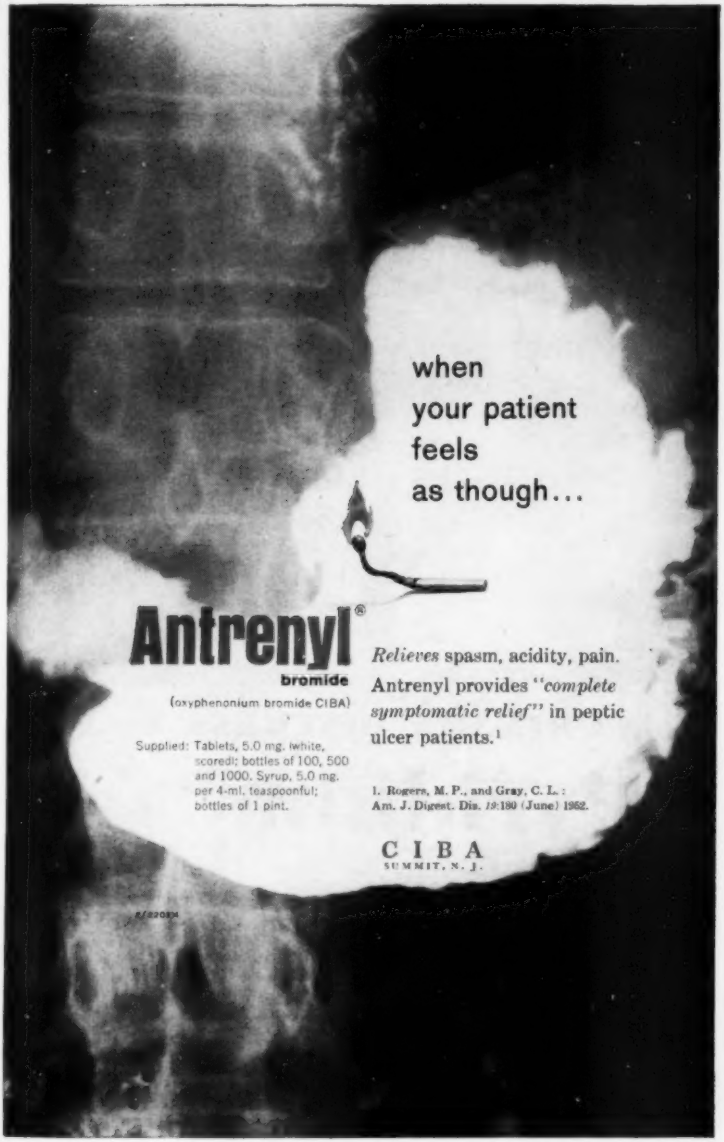
¶ *Automatically decreasing protection.* This may appear to be a drawback to some. But many doctors would actually prefer such an arrangement. It provides less coverage as the family becomes less likely to need it. So these doctors are willing to sacrifice part of their protection in later years in order to have more in the beginning.

Possible Pitfalls

So much for the reasons why the doctor might want to consider buying bank-loan insurance.

Now for some of the major reasons why, as my insurance friend said to me, "You'd better look hard before you take the plunge":

1. Some banks refuse to lend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1. Rogers, M. P., and Gray, C. L.: Am. J. Digest. Dis. 19:180 (June) 1952.
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money for insurance premiums. Other banks will do so only on a year-to-year basis. What's needed for this kind of arrangement is a bank that will agree *in advance* to increase your loan every year until the policy is paid up. And a bank that will make such an agreement doesn't necessarily exist in every locality.

2. Though most of the loan is secured by the policy itself, you need some negotiable collateral to begin with. Purpose: to cover the initial premium and part of the second. On a ten-pay $100,000 bank-loan policy bought at age 40, for instance, the annual

"Only the hands, Gilroy, only the hands."

premium will be around $7,400. So you'll have to assign bonds or other insurance policies worth perhaps $11,000 to the bank as collateral. And you'll have to leave them there until after *all* of your premiums have been paid.

Your Cost May Rise

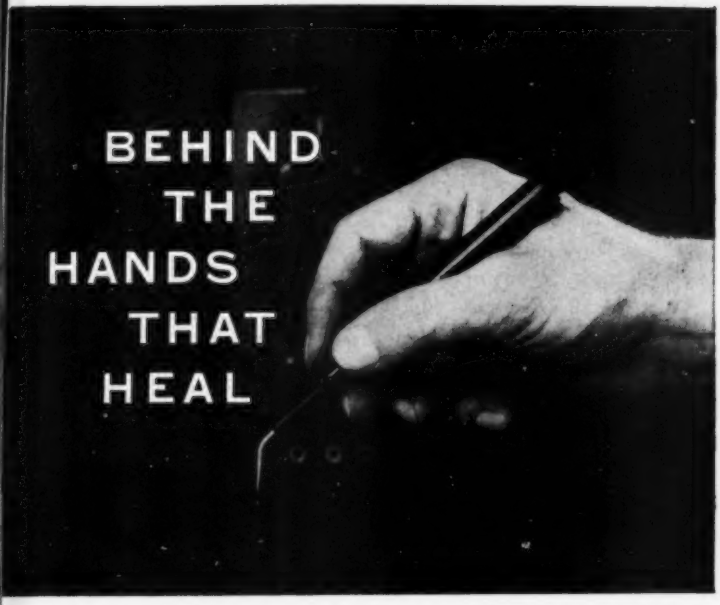
3. The bank *can* raise your rate of interest at some future time. Result: You may have to pay more than you expected for your coverage.

4. There's no guarantee, either, that insurance companies will continue to pay dividends at current rates.

5. It's possible that Congress will some day revise the Internal Revenue Code, to exclude income-tax deductions for interest paid on all loans for life insurance premiums. The Revenue Code already makes loans for single-payment policies nondeductible.

Before You Decide

6. In the long run, bank-loan insurance *is* more costly than insurance bought for cash. So the doctor should be certain he



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needs a lot of extra coverage before undertaking a lengthy program of heavy annual interest payments.

High Earnings Help

7. The plan has real merit only for the comparatively young man (under 50, say) who's in an upper tax bracket—and who has reasonable expectations of staying there. The married doctor with a taxable income of $24,000 or more can recover at least 43 per cent of his interest payments through Federal income-tax deductions. With a smaller income, the benefits of bank-loan insurance don't ordinarily justify its high cost.

After weighing the pros and cons, I decided that bank-loan insurance was a good bet for me. Is it a good bet for *you*? That's a question only you can answer.

Consultation Needed

The plan is complicated. I've by no means covered all the angles here. So I suggest you discuss it thoroughly with your insurance consultant before coming to any decision. END

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- 89.9% cure rate, shown in 4 clinical studies*, 108 cases, including many which were refractory to previous therapy. Results in *one menstrual cycle* plus a few days, with this dual treatment method. Few recurrences, demonstrated by repeated microscopic examinations
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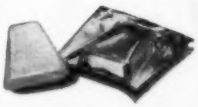

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Those
Privately Practicing Professors!

By Hugh C. Sherwood

The old battle over unfair competition has taken a new turn: Should state-supported teaching hospitals be allowed to have paying patients?

• "Socialized medicine? It isn't just a threat; it's here. Right now our state government is bent on subsidizing private practice by the faculty of our university medical school."

° ° °

"Medical schools have to pay their expenses somehow. The private practitioners don't want the Federal Government to subsidize medical education. They don't want a state subsidy. They aren't supporting us themselves. What are we to do?"

° ° °

The two speakers—one a physician in private practice, the other a medical school dean—are Oregon men. But they *could* be from any one of a number of states. Their statements summarize the opposing points of view in a growing conflict.

The question at issue is this: Should salaried medical school professors be permitted to compete with private physicians for paying patients?

Many practitioners consider such competition

unfair, unnecessary, and unethical. It's unfair, they maintain, because professors have the extra advantage of their schools' prestige. It's unnecessary because the professor's main job is teaching, and he can get all the teaching material he needs from among nonpaying patients.

Some Key Struggles Ov

Physicians in a number of states besides Oregon are currently battling against "unfair competition" from medical school faculties. Here, moving from East to West, are thumbnail sketches of the struggle in five areas:

Georgia: In 1945, the legislature authorized construction of "a hospital for the indigent sick, or near indigent sick, in conjunction with the Medical College of Georgia." Eight years later, it amended the act to permit the hospital to accept paying patients. The state medical association quickly protested that it was not "the prerogative of the medical colleges to infringe upon the domain of the private practice privileges of the medical profession." None the less, the hospital is scheduled to open its doors to paying patients later this year.

There'll be limits on the number of such patients, says the school. And fees will go into a fund tentatively earmarked for research. But Georgia's private practitioners aren't mollified. They've taken their complaint to the A.M.A.

Mississippi: In 1950, construction of a new four-year medical school and teaching hospital was authorized. The state medical association promptly conferred with school officials, urging employment of a "strict full-time" faculty that would not practice privately. But the school (now open) has approved a "geographic full-time" plan, which provides for private practice on campus and in the hospital.

Finally—and perhaps most important—it's unethical, say the opponents of private practice in the schools. Many schools collect all or part of their professors' fees. Thus they engage in the corporate practice of medicine.

An old story? Maybe. But it has recently been given a new

Professors' Private Practice

It justifies the decision as a means of attracting high-grade teachers. And it has ruled that no professor may earn more than $5,000 annually from private practice. Any excess is to go into a research fund.

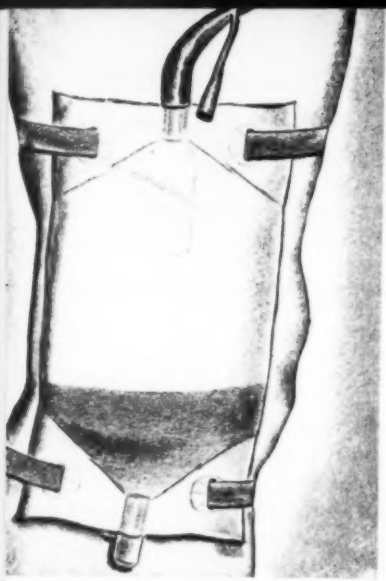
Even so, Mississippi's physicians are up in arms. Dr. John P. Culpepper, their senior delegate to the A.M.A. House of Delegates, introduced a resolution condemning "socialized and state-subsidized medicine regardless of the form which it may assume." This triggered the A.M.A.'s current investigation of the problem.

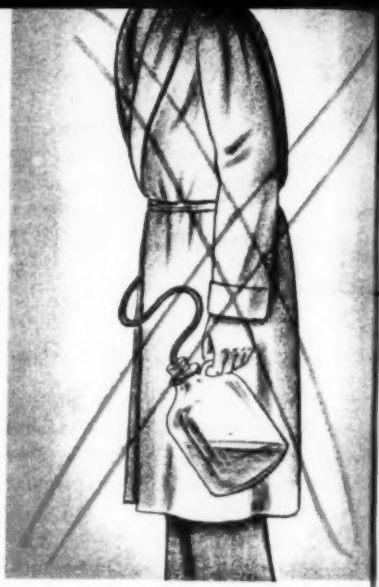
Colorado: This appears to be the only state where opponents of private practice in teaching hospitals have won their fight. They took the issue to the state legislature in 1955, after the Board of Regents had authorized the University of Colorado to construct a 100-bed private practice pavilion.

Dr. Samuel Newman, president of the state medical society, conceded that "the salaries of full-time teachers are low." But he warned against "substituting a second evil for the first." As a result of the doctors' protest, the project has been shelved.

Washington: Since the state-supported University of Washington Medical School opened eight years ago, its faculty has operated under an "interim policy" that allows limited private practice.

Three years ago, the school announced plans to open a teach-





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and disturbing twist in some places:

Several state-supported medical schools are now building teaching hospitals to which they intend to admit paying patients. And many medical men contend that this is nothing less than state subsidization of private practice. [MORE▶

KEY STRUGGLES (CONT.)

ing hospital in 1958. It said its "interim policy" would then be replaced by a "permanent" policy under which fees would be pooled to supplement the salaries of all full-time faculty members—none going directly to the earner. If this happens, it's estimated by some Seattle surgeons that the hospital will "take $2 million a year in fees away from private practitioners."

Meanwhile, the state medical association has pledged its "efforts to secure proper appropriation [for increased faculty salaries] from the state legislature." And though the school refuses to budge from its pool plan, effective limits seem likely.

California: Last May, the state's doctors asked the A.M.A. to investigate private practice not only in state-supported universities, but in privately supported schools as well. For years, reports a Los Angeles medical leader, there's been no real limit on the amount of money professors could earn there through private practice. Although the state-supported schools officially ban professors from earning more than $20,000 a year through such practice, some teachers allegedly earn an annual $100,000.

Now that the University of California and the University of California at Los Angeles have opened new tax-supported teaching hospitals, the professors have an even broader base for private practice. As a result, says the doctor, "a widening split has developed between town and gown." Private practitioners, he predicts, will refer fewer patients to the professors in an effort to destroy the "discriminative [state] subsidy."

Typical of the resultant bitterness is the current situation in Oregon, where the state university's medical school is about to open just such a teaching hospital. The school's plan has caused at least one fist fight between irate M.D.s And a few members of the school's unpaid volunteer faculty have even talked of going on "strike" if the plan is carried through.

How do such conflicts develop? Like this:

In 1944, when the University of Oregon's teaching hospital was first proposed, the state's doctors were enthusiastic about it. Their medical society worked hard to win legislative approval of the idea. And the society reaffirmed its support in 1951, when the state legislature finally appropriated money for the project.

The doctors' sole stipulation: The new hospital should admit only indigent patients, since its main goal was to provide clinical material for teaching purposes.

It soon became clear, however, that no such stipulation would be met. Dr. D. W. E.

Baird, dean of the school, supported by the State Board of Higher Education, wouldn't agree to it.

His faculty advisory committee backed his stand. In a 1953 report to the dean, this committee noted: "The ability of a particular patient to pay . . . should not prevent his admission if his type of case is needed to provide an adequate range of teaching material."

The committee recommended that paying patients be admitted to the hospital, provided "their illnesses or disabilities will contribute to the teaching and research programs of the school." And it suggested that income from such patients go into a special fund for research and equipment.

By thus earmarking all such money for the school, *not* for the faculty members, both the dean and his committee apparently hoped to avoid one type of criticism:

'Nest-Feathering'

Oregon's private practitioners have for years resented the fact that certain full-time professors have been permitted to "feather their own nests" through part-time private practice on the campus. In one such case, an

$8,500-a-year teacher has reportedly earned $70,000 annually from such campus-conducted practice.

But the assurance that no faculty man would profit financially from the teaching hospital's paying patients failed to satisfy the local doctors. In the past couple of years, they have been hammering home some strong objections to the school's announced policy. Among them:

1. Teaching hospitals don't *need* paying patients. The poor get the same illnesses as the well-to-do, and the hospital can get plenty of teaching material from them. Snapped one angry doctor: "I've opened hundreds of abdomens in my time, and I've never found a Dun and Bradstreet rating printed on a gut."

2. Faculty physicians are bound to profit from their association with the university, if only because the institution has a Director of Public Affairs to trumpet their names. "When the public gets the impression that a man's a super-doctor," complains one Oregonian, "that means unfair competition with the rest of us. Even supposing the professor doesn't get paid by his well-heeled hospital patient, it's a pretty good assump-

tion that the patient will remember that doctor's name later on."

In reply, Dr. Baird has charged his critics with exaggerating the danger of "unfair competition." Referring to Doernbecher Hospital, a Portland pediatrics hospital operated by the medical school, he's said: "Our experience [there] indicates that only 15 per cent of the patients will be able to pay hospital fees, and only 5 per cent medical and surgical fees."

The Dean's Argument

Local pediatricians, he's added, have found no fault with Doernbecher. Since its policies will be duplicated at the new hospital, isn't the medical profession crying over milk that will never be spilt?

But the local profession has continued to claim a raw deal from the medical school faction. Some examples cited:

¶ Dean Baird's advisory committee was composed entirely of full-time professors. Not a single unpaid, voluntary faculty member was included on it.

¶ Though the committee's recommendations were given to the dean in December, 1953, the medical society didn't get a

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copy of the report until nine months later.

¶ A liaison committee of medical society members tried to confer with the Oregon State Board of Higher Education immediately after the contents of the report became known. Before a meeting could be arranged, the Board accepted the faculty men's recommendation on admitting paying patients.

Alarm Is Sounded

Some months later, members of the medical society's liaison committee did manage to confer with the Board. They left the conference more alarmed than ever. It had been made clear to them that the projected hospital was expected to eat up less and less tax money as time went on. Increasing income from paying patients would make the difference.

One member of the liaison committee, Dr. A. O. Pitman, warned his colleagues at this point: "Plans are under way to establish a state system of socialized medicine under medical school auspices."

Oregon physicians, Dr. Pitman continued, were "contributing $1 million annually in voluntary services to the teaching and patient care program at the

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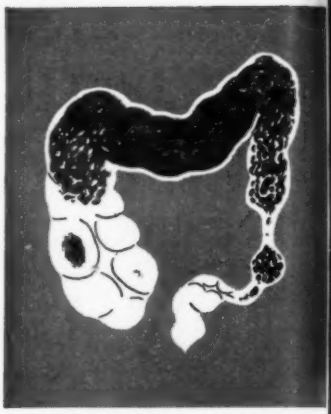

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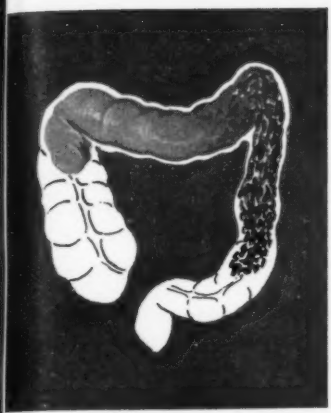

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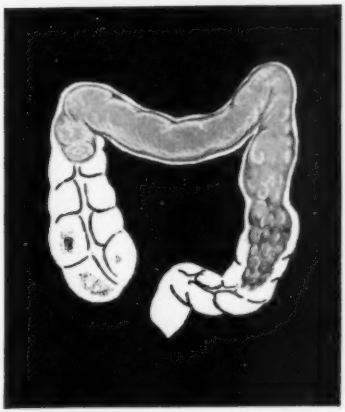

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medical school." Yet they were now learning that "medical education was responsible to the state rather than the profession."

Last-Ditch Effort

Backs to the wall, the doctors took their case to the state legislature. They persuaded the lawmakers to consider two society-sponsored bills, one of which would have specifically barred almost all paying patients from the projected institution. (The few it would have admitted could not have been charged for medical and surgical treatment.)

But both bills were pigeonholed, primarily for reasons of economy. Paying patients, it was argued, could probably save the state's taxpayers an annual $300,000.

Action Next Month

So there the matter stands. The medical school teaching hospital is scheduled to open next month. Local doctors are for the moment powerless to change its announced policies. But the state medical society

has set up a committee to investigate the school's operations, as well as those of other medical schools throughout the country.

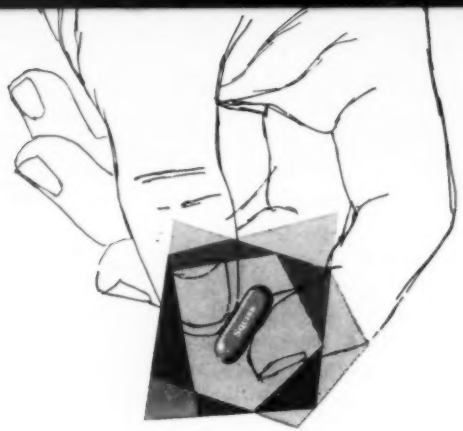
Meanwhile, Oregon physicians have adopted an attitude of watchful waiting. Some of them aren't entirely pessimistic. "After all," says one man, "maybe the school is right in predicting that only 15 per cent of its patients will pay for their care. If that's the case, we can probably maintain the status quo."

But a number of his colleagues are less hopeful. Warns one of the area's medical leaders: "It seems certain that the hospital will admit more than 15 per cent. There'll be no limit to the percentage of its paying patients."

Will They Forget?

As for the other side—well, listen to Dean Baird: "I believe the entire dispute will have been forgotten within three to five years."

He may be right. But you couldn't prove it by Oregon's embattled medical men right now. END



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Each Engran Tablet supplies:

Vitamin A (synthetic)	5,000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Thiamine mononitrate	3 mg.
Riboflavin	3 mg.
Pyridoxine HCl	2 mg.
Vitamin B_{12} activity concentrate	2 mcgm.
Folic acid	0.25 mg.
Niacinamide	20 mg.
Calcium pantothenate	5 mg.
Ascorbic acid	75 mg.
Calcium, elemental (as calcium carbonate)	150 mg.
Iron, elemental (as ferrous sulfate exsiccated)	10 mg.
Iodine (as potassium iodide)	0.15 mg.
Potassium (as the sulfate)	5 mg.
Cobalt (as the sulfate)	0.1 mg.
Copper (as the sulfate)	1 mg.
Magnesium (as the oxide)	6 mg.
Manganese (as the sulfate)	1 mg.
Zinc (as the sulfate)	1.5 mg.

Supplied in bottles of 100 and 1000 capsule-shaped tablets

SQUIBB

Licensure: What Hope for Universal Reciprocity?

By Greer Williams

The Federation of State Medical Boards wants to draft a uniform medical practice act for your benefit. But here's what it's up against

• Why can't every state honor every other state's license to practice medicine? Why can't it just collect its bounty and hand you another license when you go there?

Every year, around 7,000 doctors licensed in one jurisdiction get an additional license in another. About 6,000 manage this through some form of state reciprocity or endorsement of their credentials. (Some of these applicants run into a certain amount of red tape; but they get by.)

Nearly 1,000 doctors, however, have to take the state board examination. An unknown additional number are stopped because they don't want to take such an examination. And about 250 attempt the exam and flunk it.

No doctor, to my knowledge, has ever struck a Pat-

THIS ARTICLE *is the second of three. The first ("Licensure: It's a Mess!") appeared last month. The final article in this series will discuss the likeliest solution to the problem.*

rick Henry pose and said, "Give me liberty or give me death," about his right to practice where he pleases. But some strong statements have been made. Here's one:

"In this country, reciprocity between the state licensing boards remains one of the most urgent local needs. Given similar requirements . . . the state boards should be given the power to register a man on payment of the usual fee . . . It is preposterous to restrict in his own country, as is now done, a physician's liberty."

Who said that? The great Osler, in 1905. A half-century later, Dr. Edward L. Turner, secretary of the A.M.A. Council on Medical Education and Hospitals, said this:

Osler's Barriers

"Matters of reciprocity and endorsement, although greatly improved, still raise in many instances the same barriers described by Osler . . . I believe in universal reciprocity for individuals who meet all the basic educational requirements as a doctor of medicine."

Note Dr. Turner's use of the terms "reciprocity" and "endorsement." Both words add up to pretty much the same thing:

"Yessir, since I retired I've been fishing every day!"

Each year, as more and more people attain a ripe old age, more and more physicians prescribe GEVRAL to help keep these senior citizens fit and active. This special geriatric diet supplement provides 14 vitamins, 11 minerals, and Purified Intrinsic Factor Concentrate in one convenient, *dry-filled* capsule.

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Each GEVRAL Capsule contains:

Vitamin A	5000 U.S.P. Units	Rutin	25 mg.
Vitamin D	500 U.S.P. Units	Purified Intrinsic Factor Concentrate	0.5 mg.
Vitamin B_{12}	1 mcgm.	Iron (as $FeSO_4$)	10 mg.
Thiamine Mononitrate (B_1)	5 mg.	Iodine (as KI)	0.5 mg.
Riboflavin (B_2)	5 mg.	Calcium (as $CaHPO_4$)	145 mg.
Niacinamide	15 mg.	Phosphorus (as $CaHPO_4$)	110 mg.
Folic Acid	1 mg.	Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Pyridoxine HCl (B_6)	0.5 mg.	Copper (as CuO)	1 mg.
Ca Pantothenate	5 mg.	Fluorine (as CaF_2)	0.1 mg.
Choline Dihydrogen Citrate	100 mg.	Manganese (as MnO_2)	1 mg.
Inositol	50 mg.	Magnesium (as MgO)	1 mg.
Ascorbic Acid (C)	50 mg.	Potassium (as K_2SO_4)	5 mg.
Vitamin E (as tocopheryl acetates)	10 I.U.	Zinc (as ZnO)	0.5 mg.

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for safer, more effective relief of rheumatic pain

High concentration topical salicylate-menthol therapy (BAUME BENGUÉ) offers safe, penetrating relief of painful joints and muscles caused by overexertion.

■ *Topical salicylate therapy is being rediscovered* as perhaps the safest, most effective remedy for aching joints and muscles.

Increased percutaneous absorption of salicylate, with enhanced blood flow through the affected tissue is provided by BAUME BENGUÉ, offering up to 2.5 times more methyl salicylate (19.7%) and menthol (14.4%) than other topical salicylate preparations. In arthritis, myositis, bursitis and arthralgia, BAUME BENGUÉ induces deep, active hyperemia and local analgesia.

Lange and Weiner suggest the term "hyperkinemics" to describe preparations such as BAUME BENGUÉ which produce blood flow *through a tissue area.* They point out that hyperkinemic effect, as measured by thermoneedles, may extend to a depth of 2.5 cm. below the surface of the skin. (J. Invest. Dermat. *12*:263, May, 1949.)

Two strengths: *regular* and *children's.*

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Menthol-induced hyperemia plus high local concentration of salicylate has been rediscovered as one of the most promptly effective remedies for rheumatoid discomfort due to exposure.

Baume Bengué

ANALGÉSIQUE

in fact, the A.M.A. figures them more or less as one in its licensure statistics. But there are some important distinctions.

Two-Way Trade

Reciprocity has something of the quality of a dirty word among authorities who emphasize that licensing standards should be fair, equal, and high. Between states, it simply means a sort of fair trade agreement: "You take our guys, and we'll take your guys."

Twenty-eight of the fifty-four state and territorial medical boards have made specific reciprocity agreements with other boards.

Endorsement, on the other hand, isn't necessarily a two-way street. It's more discriminating. A board may endorse the examination you took in a state considered to have equal or higher standards than its own. If it does, you get your license without further examination.

Forty boards will endorse applicants licensed in other states—but at their own discretion. Nineteen of the forty don't have

three patients.....t

gastroduodenal and biliary pain ⇄ spasm

Prescribe the
visceral eutonic

Dactil®

Relieves pain ⇄ spasm usually in 10 minutes. Does not interfere with digestive secretions. Maintains normal tonus and motility.

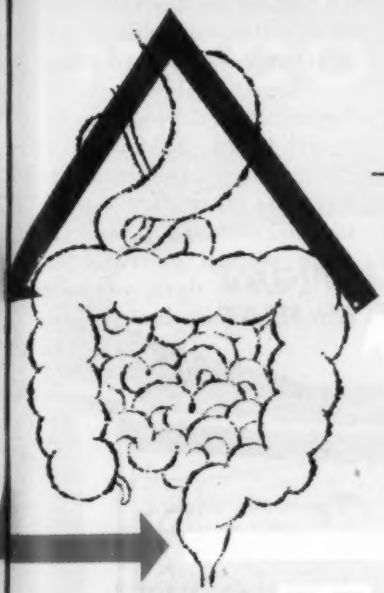
diagnosed peptic ulcer

Prescribe protection
of **cholinolytic**

Piptal®

Normalizes motility *and* gastric secretion. Prolongs remissions, curbs recurrences.

.....three piperidols



generalized dysfunction

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rapid, prolonged relief throughout the g.i. tract

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paired piperidol action

One TRIDAL Tablet two or three times a day and at bedtime is best for patients needing comprehensive control. The local action of DACTIL relieves pain and spasm almost immediately. PIPTAL enhances this relief and prolongs normalization of motility and secretion. Each TRIDAL Tablet contains 50 mg. of Dactil and 5 mg. of Piptal. Unless rapidly swallowed with water, TRIDAL will produce some lingual anesthesia. Bottles of 50.

Patients for whom you prescribe TRIDAL, DACTIL or PIPTAL remain singularly free of antispasmodic or anticholinergic side effects—urinary retention, constipation, dry mouth, blurred vision.

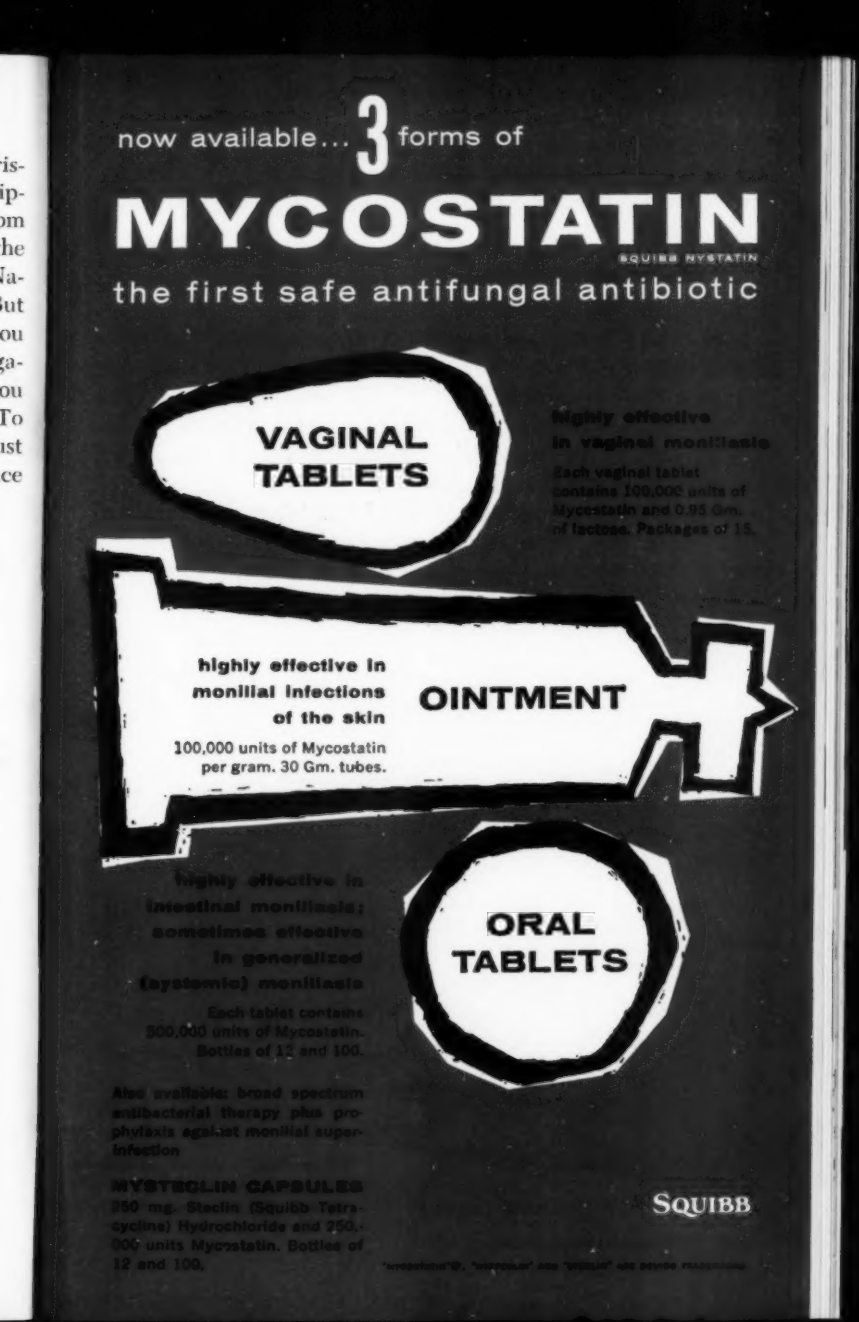
LAKESIDE

agreements to reciprocate with any other boards.

In addition, forty-five states and territories will endorse the diplomas issued by the National Board of Medical Examiners. (The National Board, as you know, gives a three-part exam to any graduate of an approved medical school who wants to take it.)

Florida, Hawaii, and the Virgin Islands are the only jurisdictions that will neither reciprocate nor endorse licenses from anywhere else. Hawaii and the Virgin Islands *do* recognize National Board diplomas. But Florida doesn't. In Florida, you face complete medical segregation and are a tourist until you prove yourself otherwise. To get a license there, you must pass the state's basic science

"I understand, Doctor. He's to cut out all smoking and drinking . . . and how about swearing?"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highly effective in intestinal moniliasis; sometimes effective in generalized (systemic) moniliasis
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ORAL TABLETS
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examination (one out of every five fails) and its licensing examination (one out of every four fails).

How Boards Vary

Admittedly, the extent of reciprocity and endorsement is better than it was a few years ago. Still, you can never be sure of who is reciprocating with whom; boards are constantly changing their rules. And you have to watch out for pettifogging restrictions. Some examples of the confusion:

¶ Texas will reciprocate or endorse a license from any state in the Union. But it will *not* approve a National Board diploma.

¶ California doesn't have any reciprocity agreements. But its board endorses more out-of-state doctors than any other jurisdiction—1,400 in 1954. Yet it requires an oral examination if the license offered for endorsement is ten or more years old.

¶ Most states tend to reciprocate Florida's cold-shoulder policy. So the Florida doctor who wants to get away from the

an agitated senile patient

. . . "no longer a disturbing element in the family"

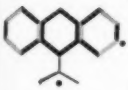
Typical 'Thorazine' Case History

patient: "This 72-year-old woman babbled constantly. She would hit at anyone who came near her and allowed no one in the home to touch the television or telephone. Her family contemplated having her committed."

medication: 'Thorazine', 25 mg. orally, t.i.d.

response: "Within a week her hyperactivity diminished. She became calm and friendly and spoke in a coherent manner. She was no longer a disturbing element in the family. . . . Six months after the start of treatment she continues to remain relatively free from symptoms."

THORAZINE*



is available as the hydrochloride in ampuls, tablets and syrup; and as the base in suppositories.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

This case report, from a general practitioner, is in his own words. Photo professionally posed.

heat can expect some cuffing around.

¶ Eighteen jurisdictions make you produce a basic science certificate before endorsing your license. Most have basic science reciprocity with certain states, but not with others.

¶ Seventeen states won't accept graduates of foreign medical schools for reciprocity, even when such doctors have cleared the many licensing hurdles in another state.

Where does this leave the concept of universal reciprocity? Is there any hope for it?

'Let Sam Do It'

A few doctors see a Federal licensing system as the only answer. One conservative has remarked: "Lord knows, I'm the last man to want to see any more Federal control of anything. But I can't help wondering whether national legislation isn't the only way to solve the problem."

Such a statement is good for a shudder among most doctors. But it's not a new idea. In 1897, the California medical society introduced a resolution in the A.M.A. House of Delegates calling upon Congress and President McKinley to pass "such laws as will regulate by national examining boards the right to practice medicine in the United States."

The resolution was defeated, and states' rights prevailed. Today there appear to be no serious advocates of Federal medical licensing. Some doctors say they don't even like the word "national." It makes them see red—not red, white, and blue.

Federal licensing will continue to be almost universally opposed as long as there's an alternative hope. *And there is some hope,* despite the following observation from one man who's intimate with the problem: "Getting cooperation among state boards is as hopeless as riding to the moon on a broomstick."

The basic obstacle to cooperation is the bewildering lack of uniformity in the laws. Naturally, state boards with good laws don't want to reciprocate with states that have poor laws.

In the last three years, however, the Federation of State Medical Boards has shown some interest in drafting a uniform medical practice act. Such a model, it's felt, would at least

for profound vasodilation in acute vasospastic disorders

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increases peripheral circulation and reduces vasospasm by (1) adrenergic blockade, and (2) direct vasodilation.

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acts primarily on the small arteries and arterioles to enhance collateral circulation.

Especially useful for long-term therapy in older patients whose feet are "always cold."

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serve as a guide to states that *want* to amend their laws.

This new hope for action seems to have been stimulated by the common threat of an invasion of displaced European doctors. State board men, medical society officials, and medical educators have been equally alarmed. Whether it's alien competition or an inferior quality of practice that worries them, the reaction has been the same.

Dr. Willard C. Rappeleye, medical dean at Columbia University, has warned: "We are rapidly creating two classes of citizens in terms of medical care received. Those of the first class will be attended by graduates of approved medical schools; those of the second class will receive medical care largely by graduates of unrecognized medical schools."

Areas of Agreement

So, in 1953, the Federation appointed a committee to draft a uniform medical practice act. The committee began by trying to find areas of agreement on the features that should be

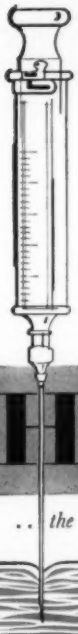
common to all such acts. It sent questionnaires to 211 medical deans and state board members. But finding something that all these persons would agree on proved to be a major task. The committee even had trouble getting its own seven members to agree.

Finally, though, it was able to present preliminary recommendations—by no means the draft of a model act—to the Federation meeting in February, 1955. Among the highlights:

1. After tussling with the problem of who should be eligible for a license to practice, the committee agreed only that the applicant should be of "good moral character," a graduate of an approved American or Canadian medical school, and an American citizen with at least a one-year interneship behind him.

2. It urged the adoption of a

"Guess again!"



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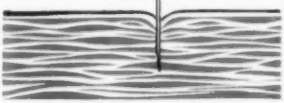

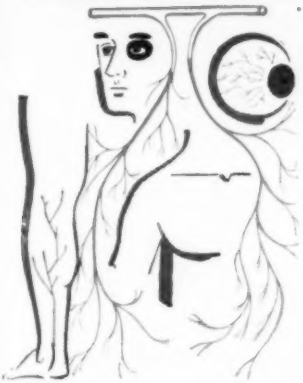

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Chronic ulcers (stasis, varicose and diabetic)
Reduction of hematomas—to hasten absorption
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Supplied in 5 cc. vials.

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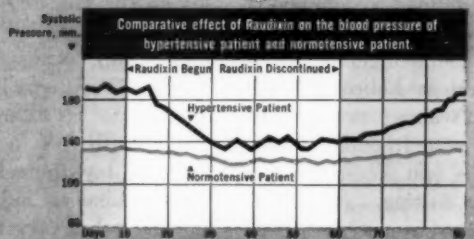
in anxiety and tension states...

stable ataractic (tranquilizing) effect without excessive sedation

in hypertension...

stable hypotensive effect without rapid peaks and declines in blood pressure



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model law that would empower the state board to set up and conduct a licensing examination as it saw fit. But since it had found "a wide difference of opinion" as to how to measure the doctor's knowledge, it outlined no specific examination requirements.

3. It suggested that the model law authorize the state board to engage in reciprocity and endorse other state or National Board examinations. But it *didn't* recommend that reciprocity and endorsements be made mandatory.

Still Hanging Fire

No final action was taken on any of the above at last year's Federation meeting. Instead, the committee's recommendations were scheduled to go through the wringer of discussion again in February, 1956. And that's about as far as the fight for your freedom to practice where you please has gone as of this writing.

Not very far, is it?

One difficulty is that the Federation is not exactly studded with crusaders. Though the conflicts of law can cause trouble for you, the general attitude of the state board men seems to be that they don't want to give *each other* any trouble.

Indeed, in reporting its survey, the committee commented: "A uniform medical practice act is Utopic and approaches the impossible."

Miracles Do Happen

Dr. Turner sums up the problem this way: "Universal reciprocity would require the revision of fifty-four laws. If this were accomplished in the next ten years, it would be a miracle."

What kind of miracle would it take to accomplish this sooner?

Well, speculate a moment:

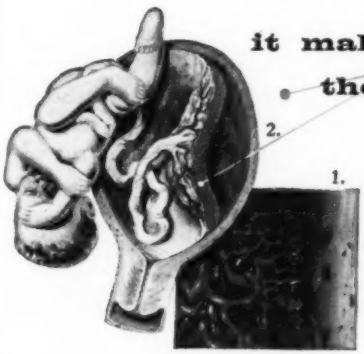
Florida is obviously the key log in the jam. Whenever the subject of universal reciprocity comes up, someone always shrugs: "Well, you'll never get Florida to go along with it." Faced with this fact, the proponents lay their hope away again. Like a faded, fragile flower, it lies pressed between the leaves of an old Oslerian text.

Florida's stubborness is simply explained. Altogether too many doctors from Brooklyn,

95% FETAL SALVAGE

with HESPER-C

it makes the difference



1. Increased fragility of the uterine capillaries leads to an effusion of blood into the decidua basalis. This is the beginning of

2. Abruptio placentae

From the ripe golden beauty of the fruit comes an influence for the finest fruition of all—the ripe offspring of love—children of today, men of tomorrow. A synergistic combination of hesperidin and ascorbic acid, Hesper-C is recommended as an integral part of any regimen for fetal salvage.[1] Maintaining capillary integrity during the critical months[2] guards against abruptio placentae. In 100 patients whose 420 previous pregnancies resulted in 95% fetal wastage, the addition of Hesper-C to current therapy completely reversed the figure and resulted in 95% fetal salvage.[3]

Remember Rx Hesper-C along with your usual therapy—it makes the difference. Maintain the integrity of the capillaries throughout pregnancy.

DOSAGE: Initially 6 capsules or more per day for the first week. Then 4 capsules daily.

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Send for samples and reprints.

The film "CLINICAL ENZYMOLOGY" is now available for showing at medical meetings upon your request. And be sure to watch for the MED-AUDIOGRAPHS, a series of recorded clinical discussions.

REFERENCES

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2. Greenblatt, R. B., Obst. & Gyn. 2:5, 1953
3. Javert, C. T., Obst. & Gyn. 3:4, 1954

PRODUCTS OF ORIGINAL RESEARCH

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THE NATIONAL DRUG COMPANY PHILADELPHIA 44, PA.

the Loop, and elsewhere want to follow their patients down for the winter. Or else they just want to retire to a practice under the palms. "We can't have them coming down here and skimming the cream off the bottle," is the way some Florida doctors put it.

The savvy outsider, on the other hand, can point out that there has been no modern test of whether Northern doctors *would* actually make any serious inroads on native Floridian practice. It was back in 1922 that the state prohibited reciprocity or endorsement.

The Miami School

The outsider may also note something else. The state has a brand new medical school at the University of Miami. Some

"Mind if I slip a diagnosis into the conversation somewhere?"

for superior performance and precision fit

B-D YALE® NEEDLES

sharp—uniform—safe

- rust-resistant throughout
- hold a sharp point
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B-D MULTIFIT® SYRINGES

every plunger fits every barrel

- fewer replacements
- longer life
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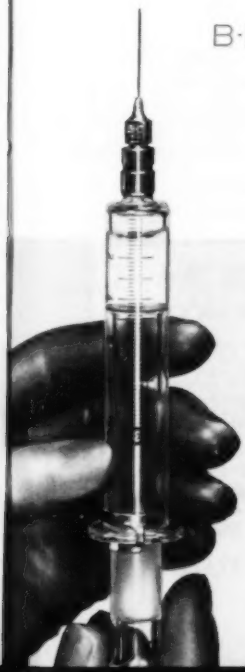

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of its graduates will want (or be forced) to go elsewhere. But they can hardly hope to do it the easiest way: by taking the Florida exam and then getting reciprocity in other states. And they won't have far to look for the cause.

Speculate a little further:

The Key Man

Dr. Homer L. Pearson of Miami is secretary of the Florida Board of Medical Examiners. He's chairman of the A.M.A. Judicial Council. He's also a member of the Federation committee to draft a uniform medical practice act.

Perhaps universal reciprocity *is* an idle dream. But if Dr. Pearson were to go before his state legislature and ask it to blast away Florida's Great Medical Barrier Reef, there are those who believe he'd be striking a blow for the free practice of medicine that would be heard around the medical world.

Barring such dramatic developments, there seems to be one realistic solution to the licensing problem. I'll take it up in these pages next month. END

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not necessarily . . .

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relief in minutes . . . Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours . . . Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

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Theophylline	2 gr.
Ephedrine HCl	⅜ gr.
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in boxes of 24, 120 and 1000 tablets

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How to Make Your Aide A Better Collector

By Frances L. Marold

You can do it, says this management consultant, by setting up a collection system your aide can run without consulting you at every turn

• Good office management pays off most directly in good collections. If it doesn't, there's something wrong. And the fault may not be entirely your aide's.

Here's how you can help her get good collection results. The incidents on which I base my recommendations are drawn from my firm's experiences with doctors throughout the Midwest:

1. *Establish a collection routine that your aide can follow with minimum help from you.*

Dr. McW was a busy young physician whose stated fees were about average for his specialty. But his income was only two-thirds of the average. So one of our consultants discussed collections with the doctor's aide.

"For over a year," she said, "I've tried to work out a better system for getting out statements. But the

---

THE AUTHOR *is associated with Professional Management of Waterloo, Iowa. This is the second of several articles by her on personnel problems in the doctor's office.*

doctor never permits me to handle them on the basis of standard fees.

"When a patient has to see him often, he reduces the fee per call. But he won't settle on a standard reduction that would help me figure charges. He keeps saying, 'I'm a physician, not a bookkeeper.' So I have to check with him about his fee for every patient; and it's a rare day when I get them all before he's called out.

He Cheats Himself

"Then, when I finally pin him down," she went on, "he seems to underestimate the services he's rendered. I hate to see him cheat himself, month after month. But what can *I* do?"

Dr. M, on the other hand, has

PEDIATRICS BULLETIN

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

EARLY RECOGNITION OF **KIDNEY TUMORS** IN YOUNG CHILDREN

IN children malignancy after the neonatal period is exceeded only by accidents as a cause of death. The two kidney tumors, Wilm's tumor and neuroblastoma, are high in frequency and usually diagnosed only after reaching great size.

These tumors have become remediable to such an extent that early diagnosis becomes important. However, both Wilm's tumor and neuroblastomata are symptomless at first, and their greatest frequency is at the age of one to three years when children are most difficult to examine and are normally pot-bellied. The mother is unlikely to help since she seldom notices even extraordinarily large abdominal masses, even with the advantage she has in the intimate handling of her child.

The runabout child of one to three years may be fairly docile on his mother's lap, or when standing, but often fights when placed on his back and demands much time and patience before an adequate abdominal examination is possible. Perhaps less of these tumors will be missed if the physician specifically thinks of them as a possibility in routine examination of every healthy appearing child at this age.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and appear periodically in Medical Economics.

devised a procedure for his aide that encourages collections in the office. She knows his standard one-visit fee, the reduced fee he'll accept from patients who can't afford more, and the quantity reduction he makes for those who get a series of treatments. That leaves little to consult him about.

Dress Rehearsal

"When I began working here, the doctor rehearsed me in my routine," Mrs. B told us. "He was eager to make sure that I'd handle financial matters with the very words he wanted me to use. Now, of course, it's smooth sailing."

As each patient ends his visit, Mrs. B offers to make the next appointment immediately. While he's at her desk, away from other patients, she can state the fee. And she can also ask pleasantly: "Would you like to pay now?"

If he's disturbed at the size of the fee, she has authority to suggest a smaller amount. Thus she's well equipped to collect a

"No, Doctor . . . inside!"

number of bills in cash every day. And she does.

2. *Consider using charge slips to boost your aide's on-the-spot collections.*

Do you believe that Mrs. B., in the above example, has *too much* authority in setting fees? Would you rather not give such responsibility to your girl?

Perhaps so. But that doesn't mean that you have to keep her guessing about specific charges. Take Miss N as an example of what can happen when the secretary isn't sure of what's going on:

"I seldom suggest on-the-spot payment to a patient," she says. "Such payments simply upset our routine. I have to interrupt the doctor and ask what he wants to charge."

Doctor Didn't Say

Once, while Miss N was talking to one of our consultants, someone phoned to ask what he owed. She stated a balance but explained that it didn't include the charge for yesterday's call. The patient asked why not. "The doctor hasn't told me the amount," the aide said. [MORE▶

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A BETTER COLLECTOR

After hanging up, she lamented: "I know it reflects on our efficiency to tell people that. Ordinarily, I confer with the doctor about his charges at the end of the day. But yesterday he had to leave early."

Actually, collections can *be* routine, instead of interrupting routine. They can, that is, if the doctor uses the charge-slip system.*

50% Pay Cash

One aide I know reports that since such slips have been introduced in her office, about 50 per cent of the patients pay cash as they leave. "That means fewer statements to send out at the end of the month," she points out. "Also, I can get all the patients' accounts posted by noon of the day after their visit. And the doctor and I don't have to waste a daily half-hour getting all the charges settled, the way we used to."

In the office that uses charge slips, the aide fills in the date and name on a slip for each patient as he arrives. When she ushers him in, she puts the slip and the case history on the doctor's desk. At the end of the visit, the doctor enters the fee

*See "Why Not Use Charge Slips?" April, 1954, MEDICAL ECONOMICS. See also "New Light on Itemizing," August, 1954, MEDICAL ECONOMICS.

on the slip, along with any extra charges.

The patient hands the filled-out slip to the aide on his way past her desk. That gives her a chance to ask about payment.

3. *Once you've established collection procedures for your aide to follow, keep as clear as you can of the details.*

Miss K told one of our consultants that the doctor had directed her to jack up patients about delinquent accounts. But she'd been none too successful at the task. "You see," she explained, "without intending to, my employer actually works against me."

She had spoken to a certain

"Quickly, Miss Everett, get my broker on the phone."

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Mr. Black, for instance. He seemed on the verge of agreeing to settle his account. But then he asked to talk with the doctor.

Recommended Remarks

When the doctor heard Mr. Black's hard-luck story, he *could* have referred the man to Miss K, with some such remark as: "I like to concentrate on treating my patients, without regard to money. I've given Miss K full authority to handle such matters. If you'll explain your situation to her, I'm sure she'll work out some arrangement that will be fair to all of us."

Instead, Miss K's employer said: "Just don't worry about the bill. Pay it whenever you can."

Story Gets Around

Now the aide frets because there's nothing further she can say to the patient. His indebtedness mounts. But if she mentions it, he can remind her that the doctor told him not to worry.

"What's worse," said Miss K,

"that story will get around. Mr. Black will tell his friends: 'Don't let *her* catch you. Talk to the doctor.' So how can I ever collect slow accounts?"

Sidewalk Situations

4. *If you do make special payment arrangements with any patient, be sure your aide knows what they are.*

Dr. S has a problem that's typical of practice in small towns: Patients stop him on the street and talk about possible ways of paying their bills. He doesn't want to make commitments that he may forget. So here's how he handles the usual sidewalk business conference:

If he and the patient come to an understanding, he says: "Will you call my office and tell my secretary what we've decided? She'll put it on the record. I wouldn't want to forget to tell her, but it's possible that I might."

His aide reports that people are very reliable about phoning her. Since the doctor has been cooperative with them, they're apparently glad to return the favor. END

Warshaw Collection

News

[CONTINUED FROM 28]

he adds, more and more clinics are accepting part-pay patients with insurance coverage. And they're "pointedly" encouraging the doctor "to endorse back to the clinic any insurance checks he receives for his services."

The net result: "The doctor now finds himself in the unenviable position . . . of being in competition with his own private practice . . . He not only has to give clinic service but has to *pay* for the privilege."

Doctors and Reporters Blame Each Other

Who's at fault when newspapers carry "premature announcements" or "overoptimistic claims" about medical advances? At a recent symposium in Washington, D.C., newspapermen blamed doctors. Doctors, in turn, blamed newspapermen, but with some reservations.

Ramsey

Here are samples of the verbal shots fired by the reporters:

¶ Asserted Frank Carey of the Associated Press: "When we write about something in the medical field, we . . . are quoting a doctor. And, if he gives his views at a legitimate medical meeting [or] in a legitimate scientific publication . . . we can only assume that his views are proper for publication . . . So, if so-called 'premature announcements' . . . appear in medical news stories, they are not our responsibility. They are the responsibility of the [doctor] who makes them."

¶ Added Nate S. Haseltine of the Washington Post and Times Herald: "Doctors . . . think a reporter has no right to report . . . that some doctor somewhere else has tried a drug for something and found it good. They seem to think *they* should be the first one to tell the patient . . . Frankly, if the public had to wait for the doctors to find out in their own medical journals about the advances in medicine, the public would have to bear its ills about five years longer . . ."

In reply to such indictments, medical spokesmen pointed out the harm that irresponsible journalism can do. "The continuous flow of . . . half-baked medical stories . . . continues to buoy up false hopes in invalids," said Dr. Herbert P. Ramsey of the District of Columbia. "In reporting, ability is not always matched by responsibility. It is not sufficient for the reporter to alibi that a doctor said this [or that]." [MORE ▶

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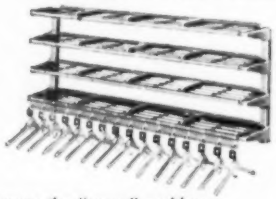
1. Rehfuss, M. E.: Indigestion, Philadelphia, W. B. Saunders Co., 1943, p. 322.
2. Shaftel, H. E.: J. Am. Geriatrics Soc. *1*:549 (Aug.) 1953.



But, he conceded, there's an "obvious greed for publicity" on the part of some medical men and institutions. And he implied that such self-seekers may sometimes lead honest newspapermen astray.

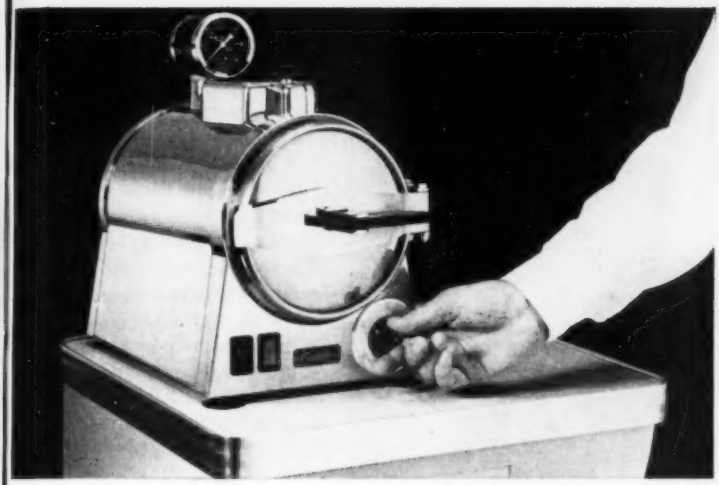
Dr. William B. Walsh berated his colleagues even more outspokenly: "We in the profession are more to blame than the press in most cases." Since medicine's code of ethics on the giving out of publicity is subject to conflicting interpretations, "how," he asks, "can we be so hard on [newspapermen]?"

Is there any solution to the problem of pleasing both newspapermen and doctors? Dr. Ramsey concluded: "The definition of news will probably forever perpetuate a disagreement between physicians and the press. [But] when I had official news to release, I dealt only through [medical reporters] We refused to deal with leg-men and sob-sisters with no scientific background." The result: "mutual respect between medical and press men here in Washington."

Doctor Survives Plane Crash, Bear Attack

True tales are sometimes taller than false ones. Take the story of Dr. Sam Sullenberger of Dandridge, Tenn.:

While sightseeing in the Great Smokies in his new Piper Cub, he crashed into lonely Mount Guyot. The plane came to rest in the trees thirty-five feet above the ground,



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and the doctor was able to climb out and down. But a mother bear and cub were there to greet him. The big bear, says the doctor, laid open his belly "with one slash."

He drove off the animals, then shivered through two nights in a sleeping bag. Finally, he staggered off in search of help—and somehow found his way to a ranger station.

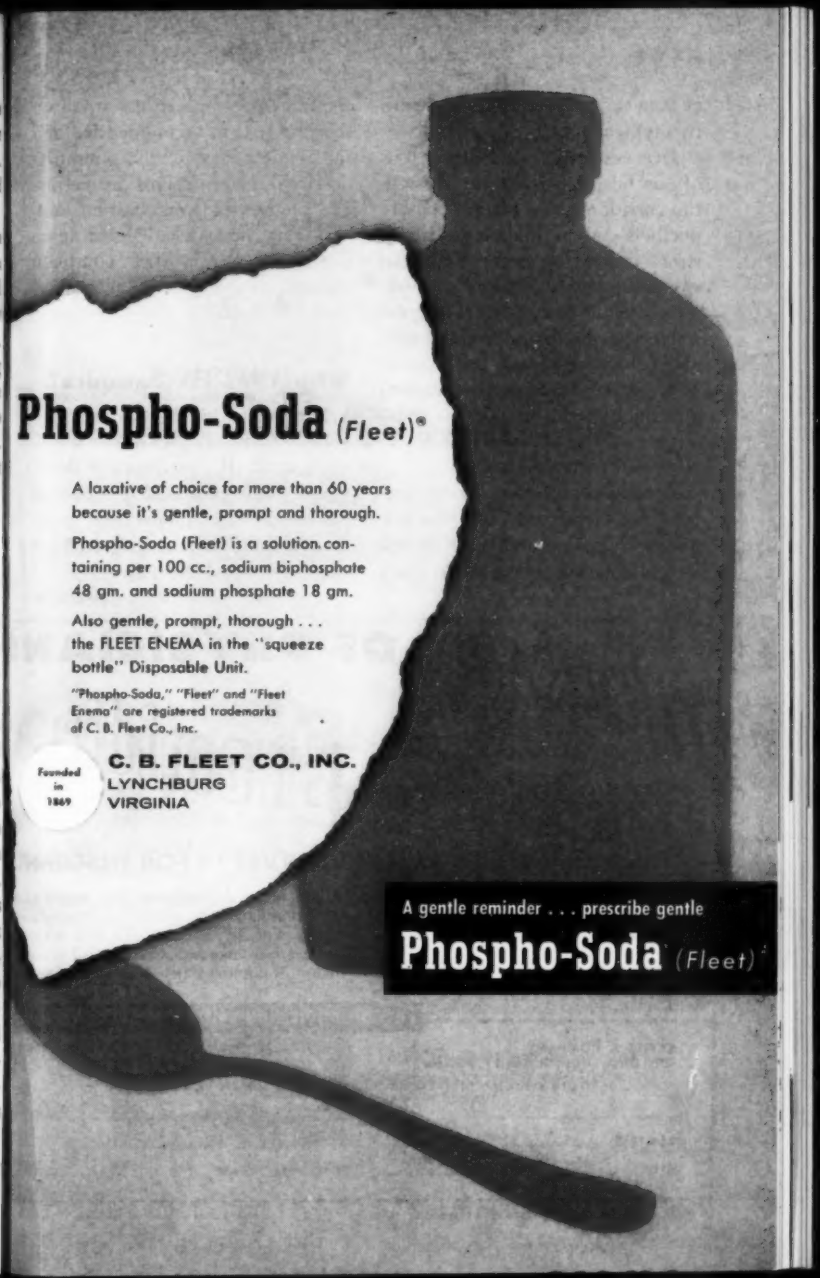
The 42-year-old doctor's feeling fine now. Just to prove his story, he returned to the scene not long ago and snapped a picture of his plane. It was still high up in the trees. But the bears were gone.

Hospitals Enlist Aid of Efficiency Experts

Think the hospital you're affiliated with is too noisy or inefficient? Then you may be interested in the experience of hospitals in New Jersey's Raritan Valley area. They've been calling on efficiency and personnel experts from industry to help them solve their problems. According to a recent report in the American Mercury, they've found that such consultations pay off handsomely.

The program began several years ago, when the New Brunswick branch of the Society for the Advancement of Management set up an advisory board for hospitals. Beginning on a modest scale, the board quickly made a name for itself. Today, it has a roster of some 200 experts, each of whom donates his services free of charge.

What problems are the efficien-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cy men called on to solve? Here are two typical ones:

Excessive noise: The report tells of one hospital where the noise in the corridors often reached eighty decibels—"about the rate for heavy street traffic." A young industrial engineer suggested some countermeasures: fiber waste cans on quiet rollers; plastic floor-cleaning buckets; rubber bumpers on brooms; volume controls on patients' radios; and door-checks to prevent slamming. Result: 80 per cent fewer complaints from patients.

Personnel problems: In one hospital, the dietary staff was continually complaining about the nurses' irregular eating schedule. To teach the kitchen people a lesson, an industrial adviser recommended giving them a view of the operating and emergency rooms in action. His suggestion was carried out; and, says the article, "Never again did the dietary workers complain about the nurses' irregular appearance for meals."

Who Uses Rx Samples?

What do you do when you find unsolicited drug samples in the morning's mail? If you dispense them, you're among the 53.5 per cent of physicians who follow that practice. If not, you're among 46.5 per cent who throw them away.

[MORE ▶

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That's the conclusion of a recent survey conducted by New York's Medical Advertising Service. Findings were based on replies from 409 physicians in twenty states.

Chiropractor's Lawsuit Backfires on Him

A nationally known chiropractor has burned his fingers in a lawsuit for the second time in twelve months. Last March, Denver's Leo L. Spears lost a giant libel suit against Collier's magazine, after he'd sued for being named a "cancer quack." Now a second court fight instituted by Spears has been won by his opponents: the Denver Post, the Denver Better Business Bureau, and the Colorado State Medical Society. The chiropractor is appealing this decision.

Spears had brought an $11 million dollar suit against the defendants, charging that they were conspiring to destroy his 800-bed chiropractic hospital. Chief reason for his pique: The newspaper and the Better Business Bureau had undertaken an investigation of his cancer "cures," his advertising methods, and the operation of his hospital.

In finding for the defense, the judge ruled that such an investigation did not constitute a conspiracy. Further—and perhaps more signifi-

cantly—he held that the Denver chiropractor was running an illegal business, since his hospital corporation employs salaried chiropractors. This is clearly illegal in Colorado, the decision pointed out.

Who Gives Anesthesia?

Only 18 per cent of today's hospital anesthesia is being given by trained anesthesiologists. Another 34 per cent is administered by nurse-anesthetists. The rest of the hospital-administered anesthesia is given as follows, according to a recent survey by the American Association of Nurse Anesthetists: 27 per cent by doctors who aren't anesthesiologists; 19 per cent by nurses who don't have A.A.N.A.-qualification; and 2 per cent by persons who aren't either doctors or nurses.

Girl in Labor Tries Do-It-Yourself Method

Because she was separated from her husband and felt incapable of supporting her expected baby, a 27-year-old Philadelphia woman recently decided to tell police she'd found the child in her basement. That way, she hoped, it would be placed in a good home.

All she had to do to make her story stick was to avoid medical care—and to deliver the baby herself. Both of which she did.

Later, under questioning, she admitted her ruse. Dr. Raphael L.

Levin was hastily summoned. "But the woman didn't really need me," he says, ruefully. "She had sat on the toilet during the actual delivery, had waited patiently for the afterbirth, had tied the umbilical cord with sewing thread, and had cut it with kitchen scissors. Then she had flushed the intact placenta down the toilet. Did a good job, too. She and her baby are fine."

Medical Society Finds Most M.D.s Inactive

Maybe most doctors in your area participate in local medical society affairs. But if so, you don't live in Philadelphia. There, the county society not long ago asked its 3,300 members a number of specific questions—and got some discouraging statistics in return. Among the published findings:

¶ Less than 6 per cent of the members attend society meetings regularly. The rest do so infrequently (60 per cent) or not at all (33 per cent).

¶ Of those who don't attend at all, nearly 56 per cent say they don't have enough time; 18 per cent complain of the parking problem; and 5 per cent indicate that they *would* attend if the meeting time were changed.

¶ One-third to one-half the doctors say that other meetings (specialty society, hospital staff, etc.) interfere with their regular attendance at county society gatherings.

¶ Less than half claim to have

even a "fairly clear" understanding of such matters as the relationship of the branch to the county organization; the procedure for new members who want to join branches; the methods of nomination and election of the board of directors; the procedure for selecting delegates to the state society; and the activities and responsibilities of standing committees.

¶ Only 20 per cent of the doctors are able to answer an unequivocal "yes" to the question: "Are you familiar with all of the services and most of the activities of the county medical society?"

Bedside Booklet Informs And Cheers Patients

More and more hospitals are making an effort to tell patients the whats and whys of hospital care. Lenox Hill Hospital in New York City is one of the latest to do so. It gives its patients a brightly written, thirty-two-page booklet designed to boost patient morale as well as to provide helpful information.

The booklet is illustrated by Jo Spier, a Dutch artist. One of its best features is a "Do You Know?" quiz that presents facts with built-in morals. Some samples:

¶ "Do you know how many miles a nurse walks in a day? . . . At least ten miles . . . !"

¶ "Do you know how many times a day a buzzer rings in Lenox Hill Hospital? 5,000 times! Of course, 398 times are on account of old

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¶ "Do you know how many times a day the telephone rings at Lenox Hill . . . ? 1,500 calls coming in! 1,000 calls going out! . . . So please don't be impatient if you have to wait a few minutes . . ."

Why You Can't Buy Flood Insurance

President Eisenhower has called for a Government program of flood damage insurance. Congressmen have introduced a host of bills to this effect. And still the question persists among some doctors: Why don't the private insurance companies underwrite this risk?

Some good answers emerge from a recent survey of insurance company executives. Their overwhelming consensus is that any property that can't be moved out of a flood area is "uninsurable."

It isn't that the companies haven't tried. Several did offer specific flood insurance some years ago. But they were forced to set such high premiums that property owners wouldn't (or couldn't) pay them. And nobody's been able to get the cost down since then.

The insurance people would like nothing better than to crack this cost nut, says an article in Best's Fire and Casualty News. But here's what they're up against:

1. What *is* flood damage? Should the companies define "flood" to include tidal and wind-driven waves,

mud flows, excessive rains in areas where there are no streams, and so on? It would be hard to make a narrow definition stick. Yet if "flood" were defined too broadly, properties that are almost *certain* to be flooded every few years would have to be covered along with the rest. Result: excessively high premiums.

2. Even if reasonable rates could be offered, only persons whose property is *likely* to be flooded would buy policies. And, in every flood, virtually all local buildings covered by insurance would probably be damaged. Result: The carriers would lose their shirts.

3. Holders of expensive flood policies would be likely to drop them following several floodless years. Result: The insurers would have too little opportunity to recoup the money they'd paid out in indemnities.

4. The expense of rating properties would be enormous. To establish a fair rate for each individual policy, the carriers would have to survey: (1) every river basin and flood area in the country; (2) every "reach" of every river; and (3) every individual property. Naturally, the policyholders would have to pay for all this.

Can the Federal Government afford to go into the flood insurance business? Not according to private actuarial standards, the insurance company executives say. But signs are that this objection may not prevent Congress from acting. [MORE ▶

In any event, if you're hoping to find a way of insuring your home or office against flood damage, you won't find it among the private carriers. Uncle Sam's way is widely regarded as the last remaining hope.

Doctors' 'Evasiveness' Causes Complaints

"The day of mysticism, [of] the prescription written in Latin, [of] the highly technical phrase, [of] the evasive half-truth . . . in doctor-patient relationship is past. The lay public is being too well educated by the lay press for the profession to suppress facts."

So says the grievance committee of the Pasadena branch of the Los Angeles County Medical Association, after reviewing the twenty-nine cases it has handled during the past couple of years. The committee—headed by Dr. Paul Hanson—reports that an appreciable number of the complaints "were brought about by evasiveness on the part of the doctor [or by] unwillingness of the doctor to discuss diagnosis, prognosis, and treatment with the patient."

One example: A doctor turned a patient over to his assistant without explaining the move. "The patient became disgruntled," says the committee. "He was antagonistic to-

ward the assistant, refused to pay the assistant's bill, and eventually became hostile toward the original doctor."

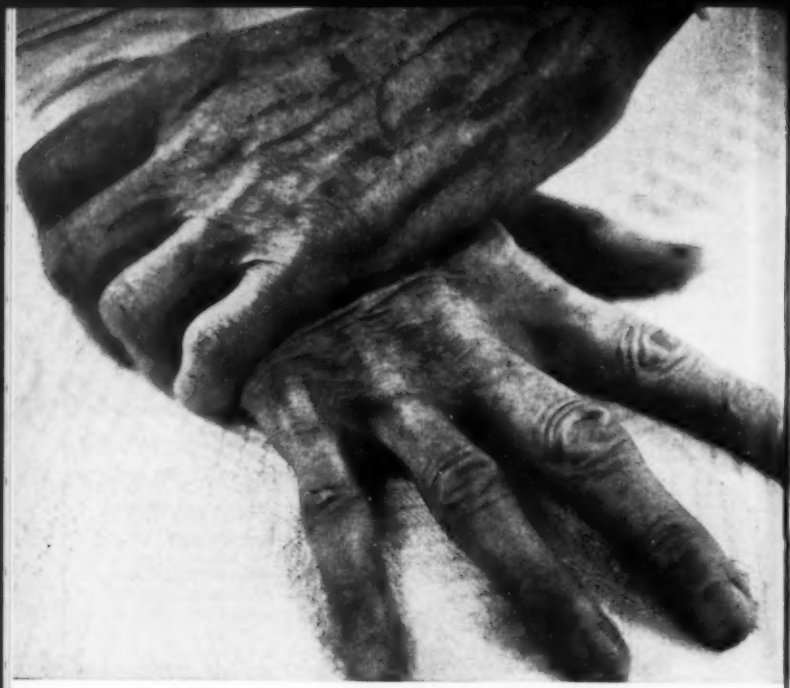
Almost as bad as evasiveness is facetiousness, says the committee. On the basis of its cases, it warns: "If the doctor does not know [his] patient extremely well, he should not joke with him."

Hospital Finds New Way To Raise Money

Hospital fund-raisers are getting more and more ingenious. One novel scheme, launched recently by the Mease Hospital of Dunedin, Fla., is called a "Gift-Participation Plan." Designed to help raise $500,000 for a new clinic-annex to the main hospital, the plan works this way:

The contributor subscribes in units of $275 (each unit payable either in a lump sum or on time). In return for his gift, the hospital promises the subscriber (or his family) a stated amount of free hospital care: $25 worth the first year and an additional $10 worth in each of the next twenty-five years. Credits may be accumulated, so that—theoretically—the donor can get his contribution back in a quarter century.

The scheme has been widely advertised in newspapers and special brochures; and hospital officials are so confident of its success that they say their new annex will be open for business by summer. END



when your patient

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'Thorazine' should be administered discriminately; and, before prescribing, the physician should be fully conversant with the available literature.

'Thorazine' acts not by eliminating the pain, but by altering the patient's reaction—enabling him to view his pain with a serene detachment. Howell and his associates[1] reported: "Several of [our patients] expressed the feeling that ['Thorazine'] put a curtain between them and their pain, so that whilst they were aware that the pain existed, they were not upset by it."

Smith, Kline & French Laboratories, Philadelphia

1. Howell, T.H., et al.: Practitioner *173*:172 (Aug.) 1954.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

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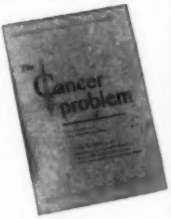
Series of textbooks on cancer by site, emphasizing detection and diagnosis, written by outstanding clinicians.



For information about these and other materials write your Division of the American Cancer Society.

*Approved by the American Academy of General Practice for Informal Study Credit.

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Memo

FROM THE PUBLISHER

Reception-Room Reading

Most physicians seem to agree that MEDICAL ECONOMICS doesn't belong in their reception rooms. But every now and then, we see a copy laid out for waiting patients to read.

If the physician isn't responsible, how did it get there?

One of our roving reporters may have the answer. In a doctor's office recently, he noticed MEDICAL ECONOMICS on display. He asked the doctor's aide about it—and learned that *she* had put it there "because people like the cartoons."

Three days later, this same man visited a sick friend in a hospital. The first thing he noticed in the patients' lounge was another MEDICAL ECONOMICS. The desk girl had put it there because "it makes such interesting reading."

In other words, well-meaning aides may be the chief reason for the magazine's appearing where doctors don't want it.

Perhaps that's the case in your office. If so, we have a suggestion: Let your aide start a scrapbook or reception-room bulletin board.

One secretary we know regularly screens all cartoons, anecdotes, and articles in MEDICAL ECONOMICS. Those that seem appropriate she pastes into a big leather scrapbook, which is kept on the reception-room table. Regular patients make a beeline for it, she reports.

Another trick is to hang a small bulletin board in the reception room. Fresh items of patient interest can be tacked up every month, and the old ones taken down.

Either way, patients can enjoy appropriate material and still not be disturbed by such professional features of MEDICAL ECONOMICS as these:

¶ It specializes in the doctor's point of view. It caters to *his* interests, prints the material *he* enjoys. This doesn't always result in reading matter that's pleasing to the average sick person.

¶ It gets strikingly clinical in its advertising pages. The photos, the color, the general eye appeal are scarcely calculated to set mothers and children at ease.

¶ It deals with the inner workings of the profession. When a patient comes to your office, you wouldn't ordinarily talk to him about such topics as malpractice suits, doctors' incomes, and collection techniques. Yet you may unwittingly be doing just that—if your secretary is in the habit of placing MEDICAL ECONOMICS on your reception-room table.

—LANSING CHAPMAN